PAY EQUITY IN PREDOMINANTLY FEMALE ESTABLISHMENTS: HEALTH CARE SECTOR

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THE VIEWS EXPRESSED HEREIN ARE THOSE OF THE AUTHOR AND DO NOT NECESSARILY REFLECT THOSE OF THE GOVERNMENT OF ONTARIO

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Chapter 1

Introduction

Background

Section 33 (2) (e) of the Pay Equity Act 1987 states that the Pay Equity Office

> shall conduct a study with respect to systemic gender discrimination in compensation for work performed, in sectors of the economy where employment has traditionally been female, by female job classes in establishments that have no appropriate male job classes for the purpose of comparison under section 5 and, within one year of the effective date, shall make reports and recommendations to the Minister in relation to redressing such discrimination.

Accordingly, the Pay Equity Office requested a study of women's work in the predominately female health sector. This study was to collect information necessary to establish which predominately female jobs would have a male job class comparable for the purpose of the Act. The study was to emphasize qualitative rather than quantitative aspects of the work, focusing on the nature and structure of employment in this sector as well as on proposals from advisory groups and on possible future trends.

Research Strategy

The Pay Equity Act indicates that there are six components that must be determined in order to establish who will benefit and who will not benefit under the Act. These include:

1. Establishment: Comparisons are made within establishments, which may include only those employees working within a particular geographical area. Therefore, it is necessary to determine the establishment before comparators can be found.

2. Employers: Not all of those working within the same organisation have the same employer. It is, however, employers who must negotiate with unions and who are required to develop Pay Equity Plans. It is therefore necessary to determine who employs the workers within an establishment. According to the Pay Equity Commission, an employer usually exercises direction and control over employees, determines compensation, hires, disciplines and dismisses employees and is perceived by employees as the employer or as the agency with the intention of creating an employer-employee relationship.

3. Bargaining Units: Employers must negotiate with unions in order to develop Pay Equity Plans. Moreover, comparisons begin within bargaining units, although comparisons may be made with job classes outside the unit if no other comparators can be found. It is necessary therefore to

determine the number and scope of bargaining units within each establishment.

4. Job Classes: Comparisons are made between job classes which are defined as jobs which have similar duties and responsibilities, require similar qualifications, are filled by similar recruiting procedures, and have the same compensation schedule, salary grade or range of salary rates. Job classes are not necessarily equivalent to occupational categories and what constitutes a job class may be a matter of debate.

Moreover, in order to qualify as comparators, jobs must be categorized as male dominated or female dominated. Female dominated job classes are usually considered to be those in which women constitute at least 60 percent of the employees while male dominated job classes are usually those in which men account for at least 70 percent of the workers. However, if jobs have historically or stereotypically been done mainly by women or men, then the percentage criteria may not apply. It is therefore necessary to gather a range of information that is essential to determining male and female job classes.

5. Wage Rates: Both job classes and comparisons are based on wage rates. Benefits are also included in the comparisons. Because comparisons can be made across bargaining units and outside the group of unionized employees, data on wages and benefits for all employees must be collected.

6. Comparators: Comparisons are based on job evaluations in terms of skill, effort, responsibility and working conditions as well as on job classes and wage rates. Study after study has demonstrated that job evaluations have traditionally undervalued or failed to consider the skill, effort, responsibilities and working conditions particular to women's work. Recognizing this problem, the Pay Equity Act calls for a gender-free evaluation scheme and makes the selection of such a scheme a matter for negotiation. In order to determine comparators, it is therefore necessary to consider the problems with traditional evaluations schemes and to contrast these to descriptions of jobs provided by employees.

With these components in mind, the following research strategy was developed:

1. A Profile of Health Care in Ontario: Drawing on data available from unions, employers, professional associations and other advocacy groups, from both provincial and federal agencies as well as from research published in the health care field, the first project was to develop a composite picture of the health care labour force and of employers in this sector. Although the Pay Equity Commission is in the process of doing a statistical analysis of women's work in Ontario, the results of this research will not be available until after the health care sector study is completed. It was impossible to research the more qualitative

aspects of the issue without first gaining a broad overview of health care in Ontario.

2. Profile of Women's Health Care Work: Central to the problem of establishing comparators is the question of how women's work in health care is to be evaluated. Drawing on published research and on reports submitted on Pay Equity in Ontario, the second project was to gain an overview of issues related to determining the value of women's health care work.

3. Profiles of Health Care Establishments: Because comparators for the purpose of Pay Equity must be found first within the bargaining unit or, failing that, elsewhere in the establishment, the impact of the legislation will vary from establishment to establishment. Drawing on interviews with employers and employees as well as with representatives from unions and employer associations, the third project was to provide case studies of individual institutions. These would provide examples of how Pay Equity would work within particular kinds of establishments.

4. The information gathered through interviews, through the literature review, through the statistical analysis and the case studies provide the basis for the final project, the outline of possible future trends and the development of recommendations on Pay Equity.

A Cautionary Note:

This research has been carried out under considerable time and organisational constraints. Contracts were let in July and the final report due in September. We are working with a new Commission, on a new project, under new legislation. The guidelines from the Commission are not yet complete. In particular, the guidelines on the information required for the purpose of Pay Equity have not been released, with the result that many people and organizations were reluctant to provide information. Furthermore, the summer schedule meant that many key people were away on vacation while others were too short - staffed during the summer months to respond to our requests for information.

Our major sources are listed in the Appendices. We have relied in many cases on information that was provided over the telephone or in face to face interviews. In some cases, the information we were given was contradictory and there are certainly gaps in our picture. We have tried however to be as thorough as time and people permitted. The speed required helps account for a certain lack of eloquence. There was no time for a careful copy - editing job.

What follows will provide more of an indication of where problems lie rather than a clear and comprehensive picture of who will and will not benefit from the Pay Equity Act.

Chapter 2

Female Dominated Jobs in the Health Care Sector

Health care work provides the classic, even the original, example of women's work and of systemic gender discrimination. Health care has always been women's work.

Native women were primarily responsible for maintaining health and nutrition, teaching the young health care habits, delivering babies, preparing medicinal herbs, setting bones, tending the sick and comforting the dying. They bore the main responsibility for the psychological and physical health of their communities. They were also responsible for training the next generation of health care providers. While Shaman were often male, women too held these "doctor" positions (see Price, 1983 and Van Kirk, 1980).

The first hospital in North America was established at Quebec by three nuns of the Hospitalières de la misèricorde de Jèsus (Kerr, 1988:5). European women also provided treatment and care in the home. As Anita Fochs Heller's (1986) research indicates, Canadian women still do.

Women of European origin did much of the "doctoring", until male organizations were successful, by the middle of the nineteenth century, in excluding women through the requirement that all doctors be licensed and have university training (Strong-Boag, 1981). These men were successful as well in prohibiting women from delivering babies, even though evidence suggests that it was often safer for a mother and child to have a midwife assist at the birth (Cayley, 1985:15).

As health care became more formalized and regulated, women were increasingly restricted by legislation and practice to a subordinate position within the health care system. This happened in spite of the fact that they had traditionally provided all aspects of care and still did most of the work.

The men in universities and government were much more powerful than the nuns and the usually poor women who provided care. Florence Nightingale responded to these developments by establishing a training system that she hoped would result in a recognition of women's work. In the process, however, this woman from the British upper classes helped institutionalize the ideas of her class and of the Victoria period (Coburn, 1974). Women in health care were established as hand maidens for male doctors.

As is the case with much of women's work, many of the skills required in health care are general, complex, overlapping and invisible. They are unrecognized in part because women have historically learned many of them outside the formal education system, from other women. Because many of these skills are also used in the home, they are taken for granted, assumed to come naturally and go unnoticed. When, for example, men who manage health care services receive training in order to communicate with workers, the skill is acknowledged. But the ability to explain details, respond to complaints, calm irate relatives and patients that is part of the daily routine for secretaries, technicians and dietary aides as well as for nurses and nurses' aides, is often unrecorded because it is not formally established as part of the training or as a job requirement. It just gets done.

Even when the skills are carefully taught by women to women within a hospital or other educational institution, they are frequently unrecognized because so many women have learned to do the work. The phrase "a nurse is a nurse is a nurse" appears repeatedly in the literature, reflecting the view that all these women do the same job. Yet the homecare nurse, for example, finds as one we interviewed points out, that "it's kind of scary doing treatments at home alone" and that "going into someone's home is different from being in charge in the hospital". For cooks, too, there are significant differences between large and small hospitals, even though it is frequently assumed "a cook is a cook". In a small hospital, cooks have to prepare special diets individually, because there may be only one patient with this requirement. Unlike those who cook in large hospitals, these cooks also do their own dishes.

Moreover, skills often disappear because more than one skill is required and more than one task is done at a time. While the tub is being filled, nurses' aides are undressing the patient, listening to her complaints about the system and her relatives, remembering how this patient likes the temperature of the water, the order in which she wants to undress and where it hurts, convincing her the bath is necessary and, at the same time, listening to calls from other patients. Physical, social and psychological skills are combined and at least six jobs are done at once.

Classic job descriptions and job evaluation schemes that focus on discrete tasks and specific skills that are more likely to be found in male dominated jobs fail to capture these more general, "womanly" skills and the wide-ranging, overlapping tasks that characterize much of women's paid and unpaid work. The problem is illustrated by an experience Timothy Diamond (1988:50) records in his participant observation study of nurses' aides. Having completed the explicitly assigned tasks somewhat early, Diamond was told that he should use the remaining time to "do some psychosocial stuff". He was shocked to realize that the supervisor saw this as a discrete task, not one that all aides do all day every day. Just as women never stop providing childcare while they are at home during the day, so too do nurses' aides never stop providing nurturing care. But all day functions disappear from job descriptions requiring allocation of time into separate packages.

Similarly, the skills involved in cleaning, doing laundry and admitting patients often go unrecorded because the women doing the job, it is assumed, are merely doing what comes naturally. Homemakers who do laundry, bathing, meal planning, budgeting, child care and provide social support are paid little more than minimum wage for what is categorized as unskilled work.

In many of these jobs, women are required to speak more than one language - a skill that is frequently not listed on the job description but one which is included when women are selected to do the job and one that is certainly necessary to do the work. Home care workers, for example, often offer services to elderly women who do not speak English and there is no one available to translate. In one nursing home we visited, more than half the staff was bilingual, and used this skill. Yet it does not appear in their job description.

Equally invisible, but even more typical of women's work, are the skills involved in planning, accommodating personal preferences and both coordinating with and relating to other workers. A useful analogy is meal preparation for a family. To get food to the table, a woman must first consider the tastes and timetables of family members, what she can get fresh at the store and how she can use the leftovers not required in the meal, the money available and the salt, cholesterol or preservatives in the ingredients, the recipes, who is available to help, how they can be persuaded to help or whose turn it is, and how to get all the food cooked at the same time and served hot at the table. Similar skills are employed by nurses, aides, and office staff every day. These jobs require an enormous amount of coordination on the floor, flexible responses from a team that takes others into account. In writing about pay equity, one nurse (Waterhouse, 1988) explained that "[W]ithin the broad spectrum of the nursing profession there are independent, interdependent as well as dependent functions which influence the means by which nursing must deliver care. By virtue of this unique and complex role, nurses must work collaboratively inside an extremely complex, multifacet health care system". On paper however, they may appear to be very similar to the jobs performed on the shop floor.

Like women's other work too, the responsibility normally required in the performance of the work is frequently unrecognized because it is usually done and because it is not part of the formal bureaucratic structure. While, for example, in the hospital the doctor is in charge of the patient, as nurse and professor Marie Campbell (1984:28) makes clear, the "Grange Inquiry shows us that, in the final analysis, the buck turns around and comes back, and stops at the nurse. We can now see that when an accident, a mistake or an unaccounted for event occurs in a hospital, individual nurses are blamed". Throughout the health care system, patients, relatives, and as the Grange Inquiry suggests, the law holds the women who provide the care responsible. Indeed they are the ones who take the day to day responsibility for producing the food, the clean linen , bath tubs and patients as well as the care but organizational structures camouflage this aspect of their work.

George Klus and Elliot Thoreson (1980:3) conclude in their study of American nursing homes that "the aide is more likely to be present at the time of a resident's death than even members of the immediate family!" In real life, the aide is often the one who must comfort the dying, inform the relatives, and begin the necessary procedures but these responsibilities are seldom included in her job description. Klus and Thoreson (1980:4) go on to explain that "when there are problems such as cold meals, missing food trays, incomplete dinners, and wrong food trays, resident impatience and frustration is usually focused upon the aide and not on the food service". Similarly, although admitting clerks may not be responsible, according to the organization charts, for delays, they are the ones blamed by patients and relatives when the doctor is unavailable or takes too long with appointments. It is, as one receptionist we interviewed made clear, the woman who is held accountable by patients. And she isusually held responsible for any errors that slip into the records.

Because so many women are concentrated in such jobs and do the work in and out of the home on a regular basis, the effort required also becomes difficult to see. Lifting the young and the old, cleaning up vomit, changing diapers, washing beds or floors, preparing endless meals day after day, moving boxes of cans, remaining patient while relatives and the sick complain again about the absent doctor or the meals, are not only dismissed as something any woman can do but also as work which requires little effort compared to male jobs. A nurse (Eagleson, 1988:2) describes how the representative of a management consulting firm discussing pay equity at her hospital categorized nursing as "one year of experience and 17 years of repetition" and went on to explain the higher pay of garbage collectors by saying "look at their working conditions". As this nurse pointed out, "Garbage collectors pick up only wrapped refuse, do not work weekends or holidays, or in very bad weather. They don't require a university education. They are not exposed to AIDS, hepatitis or other communicable diseases, they do not have to lift weights equivalent to those of a human being nor do they have to dispose of waste as objectionable as faeces or human vomit. In terms of job responsibility, garbage collectors aren't likely to kill someone if they make a mistake. Nor does their job involve the high stress of crisis situations. Nor do they have to calculate dosages and in many other ways use their brains and judgement. Yet this man apparently thought they were justified in receiving higher pay than nurses".

While men who do the routine work on the assembly line are rewarded for performing the same task over and over again, women who prepare the food on the line in the hospital are not recognized in the same way. The strain involved when a doctor must tell patients or relatives about an imminent death is acknowledged but "the constancy of sickness, the eating, defecating, vomiting, the loneliness and the dying" that are "under the continual charge of the nurses' aide" (Diamond, 1982:10) are not. George Klus and Elliot Thoreson (1980:3) argue that "Criteria for reward systems and evaluation systems of the aide may not normally include the amount or quality of personal time spent with the resident. In some instances, this time may even be considered non-productive!"

The different value attached to the effort required of female and male health care workers is particularly evident in their educational programmes. Randy Montgomery (1988:1) explains, in his brief to the Commission, that he served two full apprenticeships (one as an ironworker and one as a firefighter) and "got paid because it was a male dominated workplace". He contrasts this to student nurses, who in the first year spend 2 days a week in the hospital, pay for "their own uniforms, gas, lunch, parking, books, tuition, stationary and spend 3 days in class. It costs approximately $3,000 dollars" and the "first year nurse is given some responsibility in the hospital but mostly all dirty jobs that the RN doesn't like doing but it is still work in high demand in the workplace. There is a chance of catching a virus or an incurable disease, being attacked by a sick patient and others". He goes on to explain that the responsibility, cost and workload increase each year but the pay does not. "No apprenticeship in Ontario could match the stress, skills, knowledge as these nurses do". Most of the women involved in providing direct care also put in hours of free labour. Physiotherapists and Occupational Therapists (Ontario Physiotherapy Association, 1988:2 and Ontario Society of Occupational Therapists, 1988:1), for example, complete 1,200 hours of clinical internship.

Moreover, most of the women working in health care must be continually learning to operate new equipment and to apply new techniques. A homecare nurse interviewed for this project described how she had to learn from hospital nurses how to do intravenous medications at home. Then she had to train another nurse in the procedure. She also regularly teaches doctors about new equipment. A dietary supervisor describes how she has to not only keep up with new research on nutrition but also has to learn outdated approaches so that she knows what doctors do not know (or do know) and counteract their approach. A receptionist in a doctor's office explains how the high turnover of doctors in the north means that she is constantly retraining doctors in procedures, how she has learned to operate the new addressing machines and the computer and how she has to keep up with constantly changing regulations for OHIP and new procedures or terminology in testing. None of these new efforts have resulted in more pay.

The conditions under which health care is provided are often invisible too because they are so familiar, because women so often appear in these conditions and because they may be particular to women's situation. The noise in the factory is recognized and workers may be compensated for the racket but the noise level in a nursery or a kitchen is not. The tension created by having responsibility and little authority, or of having skills that are underutilized (Stephens, 1983 and Smith and Mintry, 1983) are frequent complaints of nurses but seldom appear on documents recording conditions of work, in part because it is assumed that women do not want control or have little commitment.

There are also structural factors that influence women's work in particular. Research (Smith, 1980:45) suggests, for example, that full-time employees in health care face less job tension than part_time employees because they have more opportunity to resolve issues that create stress. The overwhelming majority of part-time employees are women and more and more women work in health care part-time (Woods Gordon, 1985). This pattern reflects hospital policies at least as much as it does women's preferences.

One hospital administrator told us that he has trouble attracting out of town nurses because all his local nurses who work part-time want full-time employment. However, the conditions of part-time employment may not be acknowledged as more difficult in some ways than those of full-time work.

Howard Smith's and Nancy Mitry's (1983:16) research on the quality of nurses' working life also suggests that the size of the hospital has an impact on the health of nurses. They found that nurses' tension, autonomy, self-actualization and self-esteem are consistently related to the size of the hospital, with larger hospitals providing worse working conditions. Yet hospital size is seldom a factor in describing conditions of work.

Because it is frequently assumed that women are not interested in advancement, the lack of career opportunities are often not included when women's working conditions are evaluated. Research by Friss (1975) challenges this assumption, suggesting that career disillusionment is an important factor in job turnover. But university trained nurses can only move up as administrators (White 1980:70) and most health care workers have no opportunity at all for career advancement (see, for example, Briefs from the Ontario Physiotherapy Association, 1988 and the Ontario Society of Occupational Therapists, 1988). Woods Gordon (1985:vii) emphasized the problem when they recommended, in the report on RNA utilization they did for the Ontario Association of Registered Nursing Assistants, "the development of standardized criteria for recognizing RNA training and experience towards entry into related health occupations". The study Kathleen Clark (1987:7) did of Registered Nursing Assistants and Health Care Aides for the College of Nurses of Ontario also pointed out that lack of mobility is an issue for these workers. Receptionists, cooks and cleaners do not have opportunities for advancement although the dead end nature of the work may not be included in evaluations.

The demanding hours, the method of supervision, non-monetary compensation and the opportunities to provide good patient care were also mentioned to us by health care providers as part of their working conditions but these seldom appear on job evaluation forms. "In fact, the single most important factor identified by agency employed nurses as determining their choice of employment was control over working conditions. Working for an agency, nurses may select the hours, days of the week, and the shifts they work. They can specify the type of unit and the particular hospitals in which they want to work. Temporary services nurses are not subject to rewards and sanctions of the hospital system. They evade some of the usual means employed by organizations to control employee behaviour" (White, 1980:70). Study after study demonstrates that health care workers highest priority is job performance and patient care, both of which are determined by working conditions (White, 1980).

Because nurses, nurses' aides and health care aides and even the cleaners and those who deliver the food get to know the patients, the loss of a patient is more personally involving for them than it is for a doctor or administrator. This, too, needs to be considered when conditions of work are recorded.

For a large proportion of hospital workers, the job must be done in shifts. Moreover, such shift work may be more onerous than shift work done in other industries and may represent different responsibilities because of decreased staffing at night. A study (Tasto, Colligan, Skjei and Polly, 1978:iii) of 1,200 nurses and a similar number of food processors found that

"[R]otating shift workers, who not only work unconventional hours but who move from shift to shift, clearly encounter the most difficulty in adjusting their psycho-biological rhythms and patterns to their work schedules. Shift work may well pose a distinct health hazard for certain rotating shift workers".

While conditions in the laundry and office may seem more obvious, more comparable, and more easily measured, this is not necessarily the case. Many of the pressures and hazards of clerical work such as eye strain, office noises, supervision by computer, tension on the legs or back, are seldom counted. The smell and condition of hospital laundry often go unnoticed, in part because it is assumed that this kind of thing doesn't bother women. Like women in most paid jobs, these workers are also open to sexual harassment, particularly when they are unprotected by a union and are easily replaced.

Women working in all areas of the hospital face health hazards that are to some extent unique. Although like some construction workers, nurses and aides must lift heavy weights, it is more difficult to lift a resisting person who hurts in many places than it is to shift around concrete blocks. Laundresses and office staff as well as nurses, technicians, aides and cleaners are in constant contact with the ill and with materials that have been in contact with the ill. Moreover, patients and relatives of patients can become violent and abuse or attack any available hospital personnel; and those available are almost always female health care workers. As a doctor's (Shore, 1988) brief to the Commission makes clear, firemen and policemen are paid for taking risks and protecting life. Nurses have "the responsibility of medication administration, with the risk of overdosing patients and killing them with a mistake in medication, and risk of medico-legal repercussions" but the gap between the wages of nurses and those of firemen have been increasing.

Perhaps most importantly, the conditions of women's work in the hospital are often ignored because it is assumed that women are primarily motivated by and concerned with their life outside paid work; that family responsibilities are what count for women. "Friss notes that one of the prevailing beliefs of practicing managers is that turnover is inevitable because its causes are tied to the delinquency of the workers or the home-career conflicts of female employees on the health care system" (Myrtle and Robertson, 1979:18). Yet Howard Smith (1980:45) found in his study of hospital workers that the "personal characteristics of employees did not manifest any fruitful results for predicting job satisfaction, which suggests that job satisfaction results from the nature of the organizational climate". Carol Weisman, Cheryl Alexander and Gary Chase (1981:432) report on a study which concludes "That 75 per cent of 'contemplated turnover' may be attributed to job rather than family reasons" and their own research reaffirms these findings. Turnover of nurses in particular is high; the primary cause is working conditions, not family responsibilities or personal characteristics, suggesting that working conditions must be reevaluated.

The difference between women and men's pay in health care is often justified on the grounds that women work for love, not money and that women's pay provides a second, and not necessarily necessary income. A public health nurse (Daleman, 1986:2) complains in her brief to the Commission that her Board has argued that "A woman doesn't need as much as a man to live on - a woman is not a primary bread winner hence does not need to earn as much". An increasing proportion of women, however, provide the sole economic support for their households and most women's income is essential these days to maintain the household's standard of living. According to Statistics Canada research, between 1971 and 1981, the income of Canadian wives "was the significant factor in preventing family income from declining in real dollars" and family economic resources continue to deteriorate. "By 1979-81, increases in wives' income were no longer able to offset the decline in husband's average income" (Pryor, 1984:102). With housing prices in Toronto averaging $232,999 (Fennel et al, 1988:25) in 1988, most families need at least two incomes that are above minimum wage. If a homemaker earning $4.79 an hour manages to get paid for 40 hours a week, fifty weeks of the year, her gross income will be only $9,580, considerably less than $12,140 the Social Planning Council of Metropolitan Toronto (1986) estimated as the basic cost for an employed women living on her own a couple of years ago. If she was also supporting two children, as is the case for a growing number of women, she would have needed $22,327 in 1986, even before housing prices skyrocketed.

Several briefs, such as that from the Canadian Organization of Small Business (1986:16) suggest that both lack of education or career-related training and over supply or replaceability are also major factors in pay differentials between women and men. Neither of these factors provide a major part of the explanation for the wage gap in the health care field. A very high proportion of the women working in health care have post-secondary and career oriented education. This is the case for all technicians, therapists, nurses, dieticians, and many clerical workers and nurses' aides. With the exception of the doctors and administrators in the hospital, most men do not. Women and men, however, are not equally rewarded for their investment in education or training. The example given in a presentation to the Public Hearings on Pay Equity (Ontario Federation of Labour, 19 n.d.:11) graphically illustrates this point: "Vivian Lloyd has been working at Kingston General Hospital (CUPE 1974) for more than 17 years. She performs clerical duties requiring a minimum Grade 12 education. Vivian's son Eric will have been a full-time orderly at Kingston General for two years next September. The basic educational requirement for an orderly is Grade 10. Eric makes $1.07 an hour more than Vivian". Education and training cannot explain the difference. Nor can supply or easy replaceability.

Nurses are now in short supply and are difficult to replace. Wages, however, have not risen to overcome this shortage of difficult to replace personnel, as the Brief from the Canadian Organization of Small Business would suggest. Instead, as one director of a nursing home explained to us, their work is being performed by RNAs, even though according to College of Nurses of Ontario standards these women cannot perform many of the jobs nurses are allowed to do.

Many of the people we interviewed and many of the briefs submitted on Pay Equity indicate that a "study with respect to systemic gender discrimination in compensation for work performed" (Pay Equity Act, 1987; Section 33(2)(e)) in the health sector must keep these factors in mind.

Chapter 3

A Profile of Health Care in Ontario

"The collection of diverse organizations which assemble resources and produce and distribute health care is referred to as the 'health care industry.'... The health care industry does include privately owned, strictly for profit corporations, of course, but it also includes professional practices, non-profit organizations such as hospitals and voluntary societies, and government departments and agencies." (Evans, 1984:8)

Establishments and Employers

The incredibly complex health care industry includes a wide variety of large and small employers and establishments. As Table I indicates, there are close to 2 000 health care establishments, without including individual dentist and doctor's offices. Some services are provided by agency employees in private homes; some private homes provide services for agencies. Public hospitals also house or hire private services and most of the private services in or out of the hospital receive public funds. Three levels of government are involved. Many delegate their authority to regional Boards. "Local governments frequently choose not to deliver services themselves but to purchase services from private and public programs on behalf of their residents" (Manga and Muckle, 1987:56). Sorting out employers and establishments for the purpose of Pay Equity is no simple task.

Employees

Nor is it easy to determine the number, sex, jobs, bargaining units or wages of employees. According to the 1986 Census, (unpublished data) 237,310 people in Ontario had Occupations in Medicine and Health. Of these, 79 per cent were women. Those classified in health occupations account for 5 per cent of the total employed Ontario labour force; 9 per cent of the employed female labour force. As high as these numbers are, they underestimate the actual number of people working in this industry because many of the administrators, clerical workers and service employees who work in health care establishments are classified in other categories. These figures are also unlikely to include the 21 919 people within the Ontario Government who are classified as working in the health sector (Statistics Canada, 1987: Table 4).

Bargaining Units

The picture is further complicated by the large number and variety of unions, associations and bargaining units. Six major unions operate within the health sector. These include the Ontario Nurses Association (ONA), the Service Employees International Union (SEIU), the Ontario Public Service Employees Union (OPSEU), the Canadian Union of Public Employees (CUPE), The Association of Allied Health Professionals: Ontario and the International Union of Operating Engineers (IUOE). In addition, there are a myriad of smaller unions such as the Canadian Union of Operating Engineers, the Christian Labour Association and the Canadian Red Cross Blood Services Union.

ONA organizes registered nurses. Of the RNs employed in Ontario, 60 per cent belong to ONA. Within hospitals, ONA represents 78 per cent of the RNs but only 37 per cent of the nurses working in Homes for the Aged or Nursing Homes are represented by this union. The overwhelming majority of nurses working in community health also belong to ONA but few of those employed in clinics or doctors offices are represented by a union (Calculated from unpublished data, College of Nurses of Ontario and ONA.). Separate contracts are negotiated for part-time and full-time nurses. In hospitals, central bargaining takes place but this is not the case for other establishments.

The SEIU has organized 11,100 employees in 50 hospitals, some hospital ambulance drivers and 3,000 RNAs as well as some other service employees in Nursing Homes. While SEIU members are mainly employed in maintenance, housekeeping, and dietary services or work as registered nursing assistants, some other job categories are included in this union (unpublished data, Ministry of Health). Some nurses and social workers, for example, belong. Some central bargaining is done for hospitals but, unlike ONA, SEIU has not won provincial rates. Here too there are often separate contracts for full and part-time workers.

In addition to ambulance workers in private services. OPSEU has organized 2 500 technical staff in 45 hospitals. OPSEU also sits at the central bargaining table with the hospitals.

CUPE represents 15 000 service workers and RNAs in 75 hospitals, 1 700 employees in Public Health Units, municipal ambulance workers and some service workers in Nursing Homes (unpublished data, Ministry of Health). CUPE, too, sits at the central bargaining table with hospitals.

The Association for Allied Health Professionals: Ontario represents over 900 health care employees in hospitals, health units and treatment centres. Members include technicians, technologists, therapists, dieticians, pharmacists, nutritionists and laboratory assistants, among others.

With the exception of maintenance men and in some establishments dietary staff, the above unions in the health sector primarily represent women. On the other hand, the International Union of Operating Engineers and the Canadian Union of Operating Engineers represent mainly male workers in a variety of establishments.

Many of the technologists, therapists, technicians and other health care workers who do not belong to a union are members of Professional Associations that represent their interests. These Associations, however, are not certified to bargain for wages and benefits. Other workers, too, can belong to a variety of Associations or unions. An RNA, for example, may belong to CUPE, the Christian Labour Association, SEIU or no union at all. Similarly, an ambulance driver has three choices. A technician may be represented by OPSEU, by Allied Health, by an Association or by no formal organization. An individual hospital then may have more than 12 bargaining units and many Associations that make demands for their members. As well, there may be large numbers of employees who have no formal representatives.

The Structure of the Health Care Labour Force

This segregation in unions reflects the segregation within the health care workforce as a whole. As American research indicates, in spite of enormous expansion and specialization, "the hierarchical organization of the health sector has remained intact. The workforce continues to be stratified by class and race. Superimposed on both strata is a structure which segregates jobs by sex. Female health workers outnumber men by three to one yet they continue to be clustered in occupations that are lower paying, less prestigious and less autonomous than those which are predominately male." (Butter, Carpenter, Kay and Simmons, 1985: Forward)

While there are significant differences between health care in the United States and Canada, the more limited research in Canada indicates that we share with the U.S. an hierarchically organized, sex-segregated, and caste divided health care structure. Cautioning that there are major differences among institutions of varying size, Torrance (1987: 489) nevertheless argues on the basis of his research in Ontario hospitals that there are rigid divisions within health care work. "The largest single occupational group is, of course, registered nurses, who make up over one-quarter of the total full-time workers. The three other largest groups who account for just under 10 per cent, are qualified nursing assistants, the miscellaneous ward aides and unlicensed assistants and the male orderlies. Diagnostic and Therapeutic Services include a host of specialties-laboratory and radiology scientists, technologists and technicians, physiotherapists and occupational therapists, pharmacists, social workers, psychologists, audiologists, speech therapists and many other specialties. The largest component is laboratory technologists, followed by radiology technologists and physiotherapists. Within the Administrative and Supportive Services category are the management specialists, clerks, typists, etc; the dieticians and food services supervisors; the medical records, librarians and technicians; the tradesmen such as plumbers, electricians and stationary engineers; and the service workers in dietary, housekeeping, laundry and linen-service departments." Torrance (1987:491) goes on to argue that there are 3 main "castes" of hospital workers. "The top caste is composed of doctors who are 'in but not of' the hospital and a few high-ranking administrators, the second caste includes semi-professionals and technicians, such as nurses, dieticians, physiotherapists and lab personnel, and the third is formed of nonprofessional service workers who form the invisible underside of the industry." Each of these groups has very different pay scales and membership.

Certification requirements mean that, within both nursing and Diagnostic and Therapeutic Services, there is no movement among various jobs. For an RNA to become an RN, she must leave the system and follow an educational program outside the health care system. Butter et. al. (1985:44-45) argue that, although credentialing does foster professionalism, it also has negative consequences for women. "The very cohesiveness and solidarity with members of one's occupation or specialty, which credentialing mechanisms create and enhance, also runs counter to unification and solidarity among health care workers across occupational lines."

Although credentialing does not happen often in service jobs, there are rigid divisions within the service groups as well. For example, the dieticians who plan meals and the employees who make them have different lines of authority. Service and technical jobs themselves are also highly segregated. "To a large extent, the different departments constitute separate worlds where the workers remained as long as they stayed in the hospital." (Torrance, 1987:491) "For the women and immigrants who predominated in the routine technician's jobs, there were definite barriers to mounting the administrative career ladder." (Torrance, 1987:496)

Within these rigidly separated job categories, there are few opportunities to alter pay and conditions through promotions. Kahn and Westley (1983:20) found, in their study of Canadian hospitals, that all categories of workers made complaints about the lack of opportunity for advancement.

This caste system is highly segregated by sex. Torrance's top caste is dominated by men. As Table 3 indicates, men constitute 78 per cent of the physicians and surgeons in Ontario. Nearly half the men counted as working in health and medicine work in diagnostic and treatment jobs, while well over half of the women are employed in nursing therapy and related fields. Only 4 per cent of women in occupations directly related to health and medicine are in diagnostic and treatment jobs. Moreover, although women account for nearly two-thirds of the administrators in medicine and health (Table 2), men hold two-thirds of the chief executive and senior management jobs (Ministry of Health, 1987:3). Some men are scattered throughout the health care system but the only other occupations in medicine and health dominated by men are those of Optometrist, Denturist and Orderly.

More detailed data on very specific job categories do suggest that in some establishments, occupations outside diagnostic and treatment ones may be male dominated. For example, the few certified technicians and technologists in biomedical engineering (a total of 32 in Ontario) are mainly men and enough men work as electroencephalograph technologists (27 of 98) and as radiation technologists that they may dominate the field in some establishments (Health and Welfare Canada, 1988). These few men may provide the only comparators for the 34,095 women who work in what are classified as other occupations in Health and Medicine. However, these men are concentrated in the large, teaching hospitals. The only male dominated group within nursing therapy is the orderlies and these men are primarily found in psychiatric hospitals. The male dominated jobs in diagnosis and treatment may be evaluated in ways that make them ineligible as comparators for the 96 per cent of female medical personnel who are not employed in diagnostic jobs.

These tables on medical personnel do not include the many women who work in clerical and service jobs within the health care sector. Because the tape that was to supply our data on these occupations has been accidentally erased, precise numbers will have to await the arrival in the Commission of the occupation by industry data. These exact numbers, however, are unlikely to challenge the information available on the patterns by sex. Within hospitals, both these job categories are dominated by women. The 1985 Workforce Survey (Ministry of Health, 1987) found that 97 per cent of the secretarial and clerical staff was female. Both housekeeping and dietary service jobs are also done primarily by women. Women account for 70 per cent of all workers in these positions and, in smaller hospitals, they are even more likely to dominate these jobs. The only male dominated jobs outside diagnostic and nursing occupations are those in maintenance and trades. Therefore, the only comparators for the thousands of women who do service and clerical work in the health care sector will be these two job categories.

Men, then, are found mainly at the top of the health care hierarchy although some do service, skilled trades and maintenance work. A few are scattered elsewhere throughout the system. But only in a very limited number of establishments will men be found dominating engineering or other technician and technologist jobs.

Race and Ethnicity

Segregated by sex, the health care workforce is also divided by race and ethnicity, especially in large urban centres. Torrance's top caste is dominated by White, Anglo-Saxon men while the bottom caste includes a broad range of ethnic and racial groups.

A 1986 study (Head, 1986:7) conducted in response to complaints about racial discrimination in health care found that, although the proportion of Blacks and Caucasians applying for promotion was similar, a much larger proportion of Caucasians obtained the desired promotions. Moreover, 30 per cent of the sample indicated that they had been harassed by White patients and almost all of those reporting harassment were members of visible minorities. Unequal access to promotion or similar working conditions mean differences in pay.

As Torrance (1987) points out, both the service jobs and the routine technicians jobs include a large number of immigrants and members of visible minorities. A health care aide we interviewed said that "Blacks and immigrants were in special care but whites are in wards [because it is] easier. According to this woman, many of the HCAs are members of visible minorities but the RNs who supervise them are mainly White. Asked for examples of discrimination, she described how, one day she "happened to pass by the other ward in my breaktime. The RN asked me why I'm there, why aren't I doing my job. Yet the White HCA always talks to the RN. They didn't even see her not working; only talking." Cheryl Mounsey (1988) found in her study of minority healthcare workers that many felt "if I were White, I wouldn't be sitting on the bottom".

These complaints, along with the difficulty of having credentials recognized (see The Race Relations Directorate, 1987:37-40) may account for the dramatic drop (from 1 839 in 1975 to 283 in 1985) in the number of immigrants intending nursing as their occupation (Health and Welfare Canada, 1988:121).

Wages and Benefits

There are, as Tables 4 and 5 indicate, wide differences in salaries among occupations and, within occupations, between union and non-union workers. What the Tables cannot indicate are the variations from establishment to establishment. The only province-wide wage rates are the ONA rates established for nurses working in hospitals. In all other cases, wages vary even for employees belonging to the same union, doing the same job, but working in different establishments.

Provincial averages, therefore, can provide little indication of differences between female and male wages. Moreover, because nurses constitute the largest occupational category within health care, overall averages comparing female and male wages also conceal much more that they reveal. Indeed, given that such comparisons tend to leave out the largest male occupational category (physicians and surgeons) because most are self-employed, comparisons based on average wages distort relative wage structures, suggesting women are much better paid than they are, compared to men.

To provide an indication of wage gaps, Tables 4 and 5 offer examples of wages. Of the jobs given here, the male porter (who usually carries food) starts at a salary higher than all the female clerical workers listed, higher than both the non-union RNA and the HCA, higher than the female service workers and higher than the dental hygienist. The male engineers and paramedics start at a higher wage rate than nurses, therapists, social workers, technicians and technologists. Ambulance attendants start at a higher rate than all nurses except unionized ones in hospitals. The maintenance person-usually a man-earns more than RNAs and than all the service and clerical workers. Clearly, there are major gaps between female and male wages in the health care sector. However, these jobs do not appear in all establishments.

As is the case with wages, benefits are difficult to speak of in general terms. While there are standard contracts in use, there are variations from bargaining unit to bargaining unit and between union and non-union workers. Here, too, some examples provide the flavour of union contracts. ONA nurses employed full-time in hospitals have negotiated holidays with pay; holidays which vary from 3 to 6 weeks a year according to length of service. When working on other holidays, nurses are paid time and one-half. They are also eligible for sick leave pay. In the standard contract, the hospital pays for all of OHIP and Blue Cross coverage, 75 per cent of an extended health care benefits plan, 90 per cent of group life insurance and 50 per cent of dental plan costs. Nurses are also enrolled in the Hospital Pension Plan and premiums are paid by the Hospital during a leave of absence. Nurses are paid for time spent in training whether it is provided in or out of the hospital. Vacancies are posted first to nurses, seniority accumulates during leave of absence and nurses have a right to see the regular, formal evaluation of their performance. ONA nurses employed full-time in a hospital also have supplementary benefits for maternity leave and can take up to 6 months maternity leave. ONA nurses employed in the hospital part-time have similar benefits in terms of leave, evaluation, seniority and vacation. They are not, however, eligible for the health and insurance benefits available to full-time nurses.

One CUPE contract for hospital service workers covers both full and part-time employees. All employees can accumulate seniority and see any evaluations in their files. Only full-time employees are eligible for leave of absence but seniority does not accumulate during this time. It does accumulate for full-time employees on maternity leave and supplemental benefits are available to these workers during this time. Jobs for all union positions must first be posted for union members. The hospital pays for a short-term sick leave plan and time and one half is paid for overtime work. Full-time employees are eligible for 2 to 5 weeks vacation, depending on years of service. The health as well as the insurance benefits are the same as those for ONA full-time nurses. Part-time employees do not receive benefits. Instead, they are paid an amount equal to 14 per cent of their regular straight time hourly rate for all straight time hours paid. While ambulance employees in one service organized by CUPE receive similar benefits, maternity leave in this bargaining unit means loss of benefits and seniority.

Under an SEIU contract for full and part-time workers in a detoxification unit, employees are eligible for maternity leave that can be extended to 6 months. While seniority accumulates during this time, no benefits are paid by the employer and there are no supplementary payments. The Hospital pays for one short term sick leave plan for full-time employees. The Hospital covers 90 per cent of group life insurance, and half of both the extended health care coverage and the dental plan. Employees must enrol in the Hospital Pension Plan. For part-time employees, holidays with pay are pro-rated, and they receive 12 per cent of their hourly rate in lieu of all fringe benefits. The SEIU contract for paramedical employees offers basically the same benefits although there are some variations. The Hospital pays for only 80 per cent of group life insurance but does pay 75 per cent of extended health care plans. Another SEIU contract, negotiated for the part-time service group in a hospital, includes 14 per cent of regular straight time in lieu of benefits, 2 per cent higher than many other contracts.

Although benefits are fairly similar for employees who belong to unions, there are much wider variations among non-unionized workers. While no comprehensive data are available, it is clear that very few part-time, non-unionized female health care workers are eligible for benefits or extra pay in lieu of benefits. Many do not have sick leave or vacation paid for by the employer. Full-time employment does not guarantee these benefits for non-unionized employees either.

This caste divided, sex-segregated structure, accompanied by major differences in pay and possibilities for promotion, makes it difficult for the women in health care work to improve their situation.

Female Dominated Occupations

In order to understand both the difficulties in evaluating jobs and in developing comparators, this section examines in more detail the qualifications, location and union membership of the largest female dominated jobs in health care.

Registered Nurses

In order to work as a nurse in Ontario, it is necessary to register with the College of Nurses of Ontario. The College of Nurses (1987:6) describes the functions of registrants as follows:

> Every registered nurse and registered nursing assistant exercises judgement in accepting responsibility and is accountable for his or her own actions. The registered nurse and registered nursing assistant work together to provide nursing care to individuals, each contributing from an identified knowledge base.

"The Registered Nurse performs acts requiring substantial specialized knowledge, skill, and judgement, both in assessing health needs, and in planning, implementing, and evaluating nursing care. These acts include health education, promotion and maintenance of health, prevention of illness or injury, early case-finding, rehabilitation, and implementation of the prescribed medical regime. These acts are supportive and restorative to the health and well-being of individuals, families, and communities and are performed either independently or in cooperation with other members of the health team."

The College's Standard of Nursing Practice for Registered Nurses and Registered Nursing Assistants goes on to describe a broad range of minimum standards and criteria for the assessment of practice.

In order to qualify for registration, it is necessary to take either the 3 year, 6 semester Community College Diploma Program or the 4 year University Baccalaureate Course. Many nurses currently registered were hospital trained but this program is no longer offered. All these paths to registration involve clinical experience, usually in a variety of health care settings.

Of the nurses employed in Ontario in 1987, 56 per cent had Basic Diplomas as their highest qualification. A growing number, however, have university degrees. By 1987, 17 per cent had a B.A., M.A. or Phd. and 37 per cent of the Directors had a degree. Since 1982, the number of registered nurses enrolling in Baccalaureate programs has increased steadily and the number graduating directly from nursing degree programs has grown from 378 in 1982 to 558 in 1986 (Statistics Canada, 1988: Table 10). Nurses, then, have a minimum of 3 years post-secondary education and they are constantly learning new techniques as medical technologies, treatments and theories rapidly change. It cannot be argued that these women lack education, training, or job related skills.

Although increasing specialization has reduced their share of the work, registered nurses continue to constitute the largest single occupational category in the health care field. And while specialization and the expansion of the hierarchical health care structures have also led to divisions among nurses, the majority of registered nurses still do what is classified as general duty hospital nursing.

According to the College of Nurses, there were 105 356 nurses registered in Ontario as of August 27, 1987. Seventy-five per cent of them were employed and working in Ontario at the time of registration. Seventy per cent of them were working in hospitals and 73 per cent of all employed registered nurses were classified as general duty/staff nurses (See Table 6). With 98.4 per cent of these nurses women, there can be little doubt that the most common female job class in health care is that of general duty nurse.

Within the hierarchical structure of the hospital, there is a limited career path that nurses may follow. The most common senior administrative post for nurses—indeed for women within health care—is that of director but only 1.8 per cent of nurses were in this position in 1986. Another 0.5 per cent worked as associate or assistant directors. Although only 2 per cent of nurses reach these senior administrative posts, almost 11.3 per cent hold jobs as supervisor/coordinator or head nurse. Another 3.6 per cent are employed as instructors or clinical specialists. While promotions are possible for nurses, and while women dominate the more senior nursing jobs, only 17.2 per cent of the hospital posts for nurses are classified as higher than that of general duty nurse (See Table 7).

Over 40 000 of the nurses employed in 160 of the 224 hospitals in Ontario belong to the Ontario Nurse's Association. In all, 49,000 nurses belong to ONA. This union bargains centrally with the Ontario Hospital Association and has established a provincial rate for nurses. The starting rate for a registered nurse as of April 1, 1988 is $15.85 an hour, $2,575.55 a month, $30,906.60 a year. The maximum a nurse can receive, after 7 years of service is $36,166.56 a year. Separate contracts are bargained for part-time and full-time nurses, with the result that nurses may be eligible for different kinds of benefits even though they belong to the same union. In 1988, 47 per cent of the hospital nurses with memberships in ONA were employed part-time (unpublished ONA data). Registered nurses belonging to SEIU start in one hospital at $14.91 per hour and can reach $16.98 an hour.

Not all nurses do general duty work in a hospital, however. In 1987, 7 per cent of nurses were employed in Nursing Homes or Homes for the Aged. Here too, the majority of nurses are classified as general duty/staff nurses, with 51 per cent doing this work.

However, it is in the Nursing Homes and Homes for the Aged that women have the best chance of becoming a director. There are 527 nurses who are directors in Homes, and they account for 10 per cent of the nurses employed in these institutions. The high proportion of female directors is probably related to the shortage of nurses. These directors, unlike those in hospitals, often do nursing work when others are not available. Nursing Homes have very few instructors, associate directors or clinical specialists so promotion possibilities are even more limited than they are in the hospital, even though a higher proportion of nurses become directors.

Only a minority--37 per cent--of the nurses employed in these Homes belong to ONA and they are split into separate unions for full-time and part-time employees. Wage rates for nurses in these institutions are variable for ONA members and are lower than those in hospitals. To take one Home as an example, the minimum rate is $15.45 an hour and the maximum is $17.71 an hour. The maximum for nurses in 1986 was estimated by the Ministry of Health at $31,428 per year. The starting salary for the RN who does not belong to ONA is usually lower. In one home, the starting wage as of April 1988 was $13.61 an hour or less than $26,000 a year for a 36 hour week.

The third most important area of employment for nurses is Home Care/Visiting Nurse, with close to 5 per cent doing this work. Most of these nurses work for a private agency, the VON being the most important. Rates in these organizations vary considerably and few of the nurses belong to ONA. Both wages and benefits tend to be lower than in hospitals. For VON nurses that do belong to ONA, starting rates in 1987 were between $13.31 and $13.81 an hour. In most agencies, the only promotion possible is to the supervisor position.

Another 4 per cent of nurses work in Physician or Dentist offices. Few of these nurses belong to unions and their rates are often the lowest among nurses. For example, in one clinic we examined, nurses began at $12.00 an hour and there are no benefits. In most clinics, there are also no possibilities for promotion.

Public Health Units too are significant employers of nurses, accounting for 4 per cent of nurse's employment in 1987. Many of these nurses belong to ONA and, unlike hospital nurses, they have the right to go on strike. Starting rates for these nurses vary from $14.34 per hour in Renfrew and District to $16.63 in Perth. The latter rate is above the hospital rate although this is not the case in all but 5 of the 34 Public Health Units.

Of the remaining nurses, 3 per cent work in Educational Institutions, 2 per cent in Occupational Health, 1 per cent in Community Health Centres and 5 work in a variety of other small work places.

More and more nurses are working part-time every year. By 1986, employment in Ontario Nursing Homes and Homes for the Aged was almost equally divided between full and part-time workers and a third of those in hospitals worked part-time. In physicians offices, a majority of the nurses had part-time employment. Part-time work in these establishments usually means lower pay and few benefits.

None of these nurses will have male comparators within their bargaining unit. The nurses most likely to find a male comparator within the establishment are those employed in large hospitals. The many nurses who work in the 88 hospitals that have less than 100 beds and those who work outside the hospital setting are very unlikely to find male comparators because in most establishments men are clustered at the top and the bottom of the health care hierarchy and the few males scattered in other occupations are unlikely to be employed in small institutions.

Registered Nursing Assistants

Like nurses, nursing assistants must register with the College of Nurses of Ontario. According to the College (1987:6), these employees too are accountable for their actions and must work with others to provide care. In addition,

> "The Registered Nursing Assistant performs acts requiring basic knowledge, skill, and judgement in planning, implementing, and evaluating nursing care. The degree of responsibility of the registered nursing assistant will vary according to the complexity of nursing care, as determined by the registered nurse through the continuing application of the nursing process.
>
> The registered nursing assistant contributes to the

continuing assessment of health needs of individuals
for whom care is provided.
The registered nursing assistant is responsible to the
registered nurse for activities delegated by the
registered nurse."

The College also provides a detailed list of minimum standards and criteria for the assessment of the registered nursing assistant's practice.

To become a registered nursing assistant, most now complete a 3 semester, Community College Diploma Program which includes clinical experience. Students must have a Secondary School Diploma in order to enter the Community College Program. Additional courses, such as those which permit registered nurses' assistants to administer medications, are also available. Some secondary schools, hospitals and Regional Schools for Nursing Assistants have also offered the necessary training and education.

There are a third as many nursing assistants as nurses, with 34 273 registered in this province. Of these, 75 per cent are employed in Ontario. The proportion of males is higher than it is among registered nurses, although 95.2 per cent of registered nursing assistants are women.

Like nurses, assistants are heavily concentrated in hospitals. Seventy per cent work there. However, they are more highly concentrated than nurses in Nursing Homes and Homes for the Aged. Almost 16 per cent work in these institutions (See Table 8). Unlike nurses, assistants have very few opportunities for promotion in either hospitals or Nursing Homes.

Three different unions have organized RNAs who work in hospitals or Homes. These include: the Service Employees International Union, The

Canadian Union of Public Employees, and The Christian Labour Association. According to the Ontario Association of Registered Nursing Assistants (See Table 9), starting salaries for RNAs working in Nursing Homes varies with the union. For SEIU members, the rate is $10.41 an hour; for CLA members, it is $10.74 an hour and for CUPE members, $10.02 to $11.09 an hour. Rates tend to be lower in non-unionized Homes. In one we visited, RNAs start at $9.57 an hour.

As is the case for nurses, hospital rates are higher. The Ministry of Health (unpublished data) reports that the SEIU hospital rate for RNAs is $11.59 per hour and that for CUPE $11.47 an hour.

Close to 3 per cent of RNAs work in the offices of doctors or dentists and another 2 per cent work in Home Care/Visiting Nurse Services. These RNAs tend to be without a union and to have lower wages, few benefits and no possibility for promotion.

In some establishments, RNAs may find a male comparator within their bargaining unit if they are in the same bargaining unit as cooks and maintenance personnel.

Health Care Aides

Health Care Aides are not registered but many are certified. To become certified as a Health Care Aide, it is necessary to complete 120 hours of theory and 360 hours of clinical work. Up to 240 of these hours may be granted for prior clinical experience. Courses are offered in Community Colleges across the province.

The Ministry of Colleges and Universities has prepared performance objectives for those qualifying as Health Care Aides. As is the case with other health care workers, HCA must be able to work with a team. Under the supervision of an RN or RNA, HCAs are responsible for observing behaviour, for communicating with patients and for measuring various vital signs. They ensure that both patients and their rooms are clean, providing skin and foot care, brushing teeth and washing hair, toileting and turning patients, helping them with protective devices and feeding them their meals, making their beds and bathing them. They also provide care after death.

Health Care Aides are employed in Nursing Homes, Homes for the Aged, Chronic Care Facilities, Rehabilitative Institutions and private homes. There are no opportunities for advancement without retraining. We were unable to obtain figures on their exact distribution in terms of either location or sex. It is clear from the establishments we examined, however, that the overwhelming majority of HCAs are women.

HCAs may belong to SEIU, CUPE, or the Christian Labour Association, although many are not unionized. According to the Ontario Association of Registered Nursing Assistants, entry level wages for unionized HCAs range from $8.83 per hour in some CUPE locals to $9.74 per hour in some SEIU unions. The maximum wage ranges from $10.85 in some CUPE locals to $10.36 in some SEIU locals. In one non-unionized workplace we visited, HCAs began at $7.75 an hour and could make $9.84 an hour after 4 years in that institution. When a HCA we interviewed works in a Nursing Home, she is paid $6.00 an hour by the Registry Service that employs her.

In some establishments, HCAs may find a male comparator within their bargaining unit if they are in the same local as male cleaners and kitchen porters or maintenance personnel.

Therapists

There are Audio and Speech Therapists, Physiotherapists and Occupational Therapists. The overwhelming majority—88 per cent—are women. As of 1987, there were 3,636 Physiotherapists and 1,899 Occupational Therapists registered in Ontario.

To become a therapist in Ontario, it is necessary to complete a 4 year Baccalaureate degree and 1 200 hours of clinical internship. Many practicing therapists have advanced degrees. According to the Ontario Physiotherapy Association (1988:2) mobility "within the profession of physiotherapy is limited...the opportunity for vertical advancement from the staff therapist level is limited". The Ontario Society of Occupational Therapists (1988:3) also claims that mobility is restricted. "There is little remuneration given for merit or for educational upgrading even though such professional development is expected...Opportunities for advancement are limited and wages for management positions are subject to pay inequity".

"Physiotherapists use their skills and knowledge in the area of musculoskeletal, neurological and cardio-respiratory disorders to assist their patients in restoring optimal physical function" (OPA, 1988:1) "Occupational therapy is a health discipline serving people with disabilities which impede their functional or adaptive behaviour and whose occupational performance in the area of self-care, productivity and leisure is impaired by illness, injury, emotional disorders, social disadvantages or the aging process." It is "a client-centered process involving screening of clients, assessment, program planning, intervention, discharge planning, follow-up and evaluation...It requires an integration of knowledge including biological, behavioural, and social sciences to increase the functional capacity of clients." (OSOT, 1988:1-2)

"Approximately 79% of physiotherapists work in the broader public service." (OPA, 1988:1) and most of the rest are employed in private clinics. Of the Occupational Therapists, approximately 72 % are employed "in hospitals or other health care facilities, 21 % in home/care community care services, 4 % work in private practice and 3 % in the educational system" (OSOT, 1988:2) We did not obtain figures on the distribution of Audio and Speech Therapists, but they too are likely to be concentrated in hospitals and clinics within the broader public sector.

There are 86 Occupational Therapists, 238 physiotherapists and 25 Audio or Speech Therapists who belong to Allied Health. A few more belong to other health sector unions but the vast majority belong only to their respective Associations.

"Over 70 % of registered physiotherapists are staff therapists with an average annual salary range between $30,400 - $35,000." The physiotherapy fee set by OHIP is $10.40 per treatment but a physician billing for such services receives $11.50 per treatment (OPA, 1988:2-3). Staff Occupational Therapists have annual salaries ranging from $32,400 to $35,900 (OSOT, 1988:3). A unionized Speech Therapist's salary ranges from $29,556 to $35,634 a year.

In many establishments, there will be no male comparator for therapists. It may be possible, in some places, to use pharmacists, engineers or accountants as comparators, if these can be established as male dominated job classes with higher pay.

Technicians and Technologists

Approximately 20 000 people work in medical, radiology, respiratory and dental laboratories and departments as technicians or technologists. Close to three-quarters of these technicians and technologists are women.

There are a wide range of programmes and requirements, but in general, to be registered as a technician or a technologist requires a minimum of two years Community College training after the completion of Secondary School. The responsibilities and functions vary so much among these jobs that they cannot be briefly summarized here.

Technicians and technologists are employed in both private labs or clinics and in hospitals but we could not obtain data that provided figures on their distribution. Some hospital-employed technicians and technologists are unionized but the majority of those in private establishments do not belong to a union. Wages vary significantly with establishment and with whether or not employees belong to a union. As Table 4 indicates, technologists are paid more than technicians.

In some establishments, some technician or technologist jobs may be male dominated. For the many women who work in private clinics or labs, there are unlikely to be male comparators unless there is a maintenance man who is paid more. Those employed in large hospitals may be able to establish a comparison with paramedics, ambulance drivers or those working in trades. In smaller hospitals, the maintenance person is likely to be their only comparator.

Dietary Aides

There are a wide range of jobs done in the kitchen and the overwhelming majority of them are done by women. There is, however, often a male cook paid the highest wage in the kitchen or a male porter who is paid more than the female dietary aides.

Dietary aides do not have a registry and there are no formal qualifications other than basic literacy listed in job descriptions. The only promotions possible is to the supervisor category or, in some hospitals, through several grades of dietary aide.

Although specific duties vary from establishment to establishment, most dietary aides are required to wash dishes and clean the cooking areas, make up food trays, prepare desserts and assist with the serving of meals.

Dietary aides are employed in Hospitals, Nursing Homes, and various residential centers. Data on their precise distribution is not available. They may belong to one of three unions. Those in hospitals are more likely to be unionized than those in Homes or smaller residential centers.

Wages vary with establishment and among unions as well as between union and non-union employees. CUPE members in one hospital begin at $9.41 an hour and can rise to $9.83 an hour. In a non-union Home, the starting wage is $7.75 an hour and the maximum is $9.84.

The only male comparators may be the maintenance personnel.

Housekeeping and Laundry

Jobs in both housekeeping and laundry are also female dominated but if men work in these areas, they are usually in the highest paid job categories.

Wages, qualifications on job descriptions, comparators, and opportunities for advancement are the same as those for dietary aides. These workers are eligible to join the same unions as the dietary aides and are employed in similar establishments. Laundry workers sort laundry, feed and unload machines, fold and deliver clean laundry. Some also iron and mend. Housekeeping staff do a wide range of cleaning jobs throughout their institutions, although distinctions are often made between the men who push machines and the women who clean toilets. The men are paid more for machine-aided work.

Clerical Work

There is an enormous variety of clerical jobs in the health care sector and almost all of these jobs are done by women.

Most clerical jobs require a minimum of Secondary School completion with special skills training and many require Community College or University courses. A language in addition to English is often necessary. There are also many specialized tasks in the health care sector that require specific training. Admitting and Records provide just two examples. Moreover, much of the information processed in health care establishments is confidential.

Although there are a wide range of clerical jobs in many establishments, opportunities for advancement are quite limited in most sectors. Administrators are usually introduced from other areas, not recruited from the ranks.

Almost all health care establishments require clerical staff, given that record keeping is a central feature of health care. Although some clerical workers belong to OPSEU or CUPE, most do not belong to a union.

Clerical workers are, in many institutions, among the lowest paid workers. They may find a comparator among maintenance workers or cleaners in larger establishments but in the many small establishments, comparators will be very difficult to find. Because they are among the lowest paid, they are likely to find their salary raised if there is a male comparator.

Establishments Under the Ministry of Health

The following section describes the establishments listed in the Appendix to the Pay Equity Act 1987 under Ministry of Health.

1 (a) Ambulance Service

There are 166 ambulance services in Ontario that receive transfer payments from the Province but are not operated by the Ministry of Health (unpublished data, Inspection and Investigation, Ministry of Health). A total of 3,617 people work for these services, and 18 per cent of them are women. However, 579 of these people are volunteers. Of the paid employees, 15 per cent are women. Over 70 per cent of the women employed in these ambulance services work as driver/attendants but they account for only 11 per cent of the workers in this job class. Even though fewer women work as dispatchers, they constitute 51 per cent of this job class. While a high proportion of dispatchers are women, their numbers are not sufficient to make this a female job class and it would be difficult to argue that it has traditionally been a female work.

There are no female job classes evident in the non-Ministry ambulance services taken together. However, these services will be treated as separate establishments with separate employers. Although men dominate the driver/attendant job class in all services, there are no male dispatchers in

11 of the 166 services and women account for more than 60 per cent of the dispatchers in another 7 services. There may be, then, 18 services that have both male and female job classes. Whether or not this will result in pay adjustments will depend on both current pay and on job evaluations. In the ambulance service we examined, dispatchers are paid more than driver/attendants. That is, what could be defined as a female job class in some cases is more highly paid in this service than the male driver/attendant class.

There are also 9 ambulance services operated by the Ministry of Health. While we did not obtain data on employees in these services, they too are unlikely to have a female job class in most of their establishments.

It is interesting to note that the majority of both males and females who work in these services are between the ages of 20 and 24. Employees may belong to CUPE, OPEU or SEIU or no union at all.

1 (b) A Nursing Home

There are 333 licenced Nursing Homes in Ontario. These Homes vary in terms of size and services. Although many are independently owned and operated, a significant proportion are part of chain operations. It is not yet clear whether each of these chain-operated Homes will be treated as a separate establishment or whether they will be grouped by region. Mainly private, for-profit, these Homes nevertheless receive most of their funds directly or indirectly from the government.

Neither the Ministry nor the Ontario Nursing Homes' Association collect data on the total number of employees, the sex distribution of jobs or the range of jobs performed in these facilities. According to the Ontario

Statistician, this paucity of data reflects "the low number of facilities (about 40 %) that report regularly to Statistics Canada." The Ontario Nursing Homes' Association has hired a consulting firm to help them work on Pay Equity but our contact from that firm said that they are not collecting data on total numbers of employees or the sex of workers.

The Association has begun to collect some data and estimates that 24000 people work in these homes. (The Ministry estimates 25 000 full-time equivalents.) Approximately 2 000 of these are men. The men are concentrated in 3 areas; administration, janitorial and maintenance work. All other jobs are female dominated. These Homes employ more RNAs than RNs and an increasing amount of work is done by Health Care Aides or Nursing Attendants. Significantly smaller than many hospitals, these Homes also employ a few clerical workers. There are, however, fairly large numbers of women employed in housekeeping and dietary services. These homes usually have an activity director as well.

Four unions organize in these homes. These include: ONA, SEIU, CUPE and the Christian Labour Association. Only a minority of employees are unionized, however.

Wages vary from Home to Home even among unionized workers and the wages are lower than those in hospitals. In one Home, wages for RNs ranged from $13.61 to $17.31; for RNAs, from $9.57 to $12.13; for HCAs, from $7.85 to $9.94; for housekeeping and dietary aides as well as nursing attendants, from $7.75 to $9.84 an hour. The starting hourly rate for janitors was $10.38--higher than all the women except the RNs--and the maintenance workers began at $11.41 an hour.

Most homes will have male dominated janitorial and maintenance job classes to compare with female dominated dietary, housekeeping, clerical, aide and RNA job classes. It is very unlikely that RNs will find any male comparators, unless they can use male administrators as a comparable job class. In a significant number of homes, however, this too is a female job class.

1 (c) Laboratory or Specimen Collection Centres

There are 11 regional public laboratories and 1 central public laboratory.

These regional laboratories employ a total of 221 people, 72 per cent of whom are women. In addition, a number of students are employed during the summer months.

The men are disproportionately found in senior and management positions that fall outside the union. Close to 45 per cent of the men are in these jobs. All but one of the directors is a man. If these men in senior positions are removed from the calculations, then over 80 per cent of those represented by OPSEU are women. The only male job classes among union members in the labs will probably be those of manual labourer and driver; positions found in only some labs.

The Central Laboratory employs a total of 118 people. The largest job category is that of technologist, although many people also do various kinds of clerical work. Over 70 per cent of those employed in this Central Laboratory are women. Here too, men are disproportionately found in the senior and management positions. A third of the 34 men hold these kind of jobs. While another 11 men work as technologists and 8 as laboratory assistants or attendants, none of these jobs are male dominated. The only male job class among the OPSEU membership in the Central Laboratory is likely to be that of labourer.

There are, in addition to the public laboratories, 224 private labs and 255 specimen collection centres. These labs employ a total of 3 797 people. Of these, 323 have a Master's, Doctorate or Medical Degree, 1 936 are technologists and 1 538 are technicians. The Province does not have information on the sex of these workers but it seems likely, given the pattern in public labs, that the technologist and technician categories are female dominated and have little chance of finding a male comparator.

1 (d) A Psychiatric Facility

There are 10 Provincial Psychiatric Hospitals with a total of 4 831 approved beds. In addition, 65 Public Hospitals include 2 201 beds approved for psychiatric patients. There are also 8 Miscellaneous Psychiatric Hospitals with 991 approved beds and 2 Private Hospitals with 30 approved beds. As is the case with hospitals in general, the Ministry keeps records on the numbers and sex of patients but not on the number and sex of employees (Ministry of Health, 1988:147-148).

While each of the Provincial Psychiatric Hospitals as well as the Miscellaneous Psychiatric Hospitals will develop Pay Equity Plans specific to their psychiatric facilities, in the other hospitals the facilities will be included with those providing a wide range of services.

There may be some male comparators specific to the psychiatric hospitals. In the one we examined, the psychiatrist attendants were all male. These attendants are paid more than RNAs but less than RNs. There was also a large number of staff psychologists. However,in this hospital, there was an equal number of female and male psychologists.

1 (e) A Home for Special Care

Definitions of Homes for Special Care vary somewhat and very different figures are provided on their numbers. The special care grouping for Statistics Canada includes Nursing Homes, Homes for the Aged, Home for the Mentally Handicapped, for Alcoholism and for Children's Treatment Homes.

According to one person we spoke to in the Ministry, there are 226 Homes for Special Care which consist of private homes that provide accommodation for ex-psychiatric patients. The Ministry pays for the service but the householders are not employees and do not hire employees. Therefore, there would be no need for a Pay Equity Plan.

1 (f) Home Care Facility

The Ministry of Health hires agencies to provide some home care services. Most of these services fall under the Ministry of Community and Social Services and will be covered in the report in that area. The VON provides many of the home care services paid for by the Ministry of Health.

Victorian Order of Nurses

The VON operates 33 branches in Ontario, employing approximately 2 000 people who work as nurses, occupational and physical therapists, nutritionists and social workers. In addition, the VON hires clerical staff. Financial support comes from the Ministry of Health's Home Care Program and from fundraising campaigns.

Six of the branches are unionized, although 2 of these branches are on their first contract. Only the nurses belong to a union. Although the nurses are members of ONA, their wage rates are not provincially set and are lower than hospital rates.

Each branch pays its own expenses and may constitute a separate establishment for the purpose of Pay Equity. We were unable to obtain data on the sex composition of the VON workforce but if the branch we examined is any indication, there are unlikely to be any male comparators in these branches.

The VON provincial office employs 10 people, including an administrator, senior executive personnel, computer experts and other clerical staff. Of these, 9 are women. There are unlikely to be any male comparators.

1 (g) A Rehabilitation Centre or a Crippled Children's Centre

According to our informant in the Ministry there are, in addition to the Rehabilitation Hospitals and the services within General Hospitals, 52 Rehabilitation Centres. These centres vary in size and collecting data on the number of employees would involve contacting each one. They are generally small, however, and mainly employ supervisors and cleaners.

As of 1987, there were 16 Children's Treatment Centres in Ontario. They employed 362 full-time and 152 part-time staff. No data was available on the sex of employees. The size of the staff varies from Centre to Centre, ranging from 67 in London Thomas Valley to 9 in Sudbury Laurentian (Ministry of Health, 1988:129).

1 (h) A Detoxification Centre

There are 25 Detoxification Centres in Ontario. There are no data available on total number of employees or on their sex. Four of these Centres are for women only and the rest do not specify who can enter. However, these 21 Centres are likely to provide facilities mainly for men. In the Centres for men, most of the employees are male while the reverse is the case for Centres which serve women.

1 (i) An Adult Community Mental Health Centre

The 236 Adult Community Mental Health Centres vary in size but most are small. Some are connected to Agencies, others to Hospitals and some are independent. Centres are funded by the Ministry and the Ministry determines wage rates but each Centre does its own hiring. It is therefore likely that each would be considered a separate establishment although one Agency may have several houses in the same geographic area.

Some houses provide 24 hour supervision and others provide no supervision. The largest Centres include case managers and directors, counsellors, social workers, secretaries and bookkeepers. No data are available on the total number or sex of employees. It is very difficult to estimate whether or not there will be male comparators, given that significant numbers of men can be found in all but the secretarial job class in most institutions.

1 (j) A Placement Service, the operation of which is pursuant to a "Placement Coordination Service Agreement."

There are 19 Placement Coordination Services throughout Ontario. These Services, which are funded by the Ministry of Health, coordinate the placement of people into long term care facilities. The Placement Services arrange for an assessment of client's functional and medical needs and then place clients' names on a master waiting list for the appropriate facility in the area. While use of the Services is optional and while clients may choose to ignore recommendations, the Ministry encourages clients to go through these Services in order to ensure that beds are efficiently allocated and clients appropriately assigned.

The majority of these Services are under the authority of the VON, Public Health Units or hospitals. There are, however, 4 Placement Services that are independent of these organizations and these would probably constitute separate establishments for the purpose of Pay Equity. These 4 establishments employ a total of 12 people, although the number of employees will increase this year. All of the employees are women. Of these, four work as coordinators, 4 as case managers and the remainder have clerical jobs. None will see their wages change under Pay Equity.

2. District Health Councils

There are 26 District Health Councils in Ontario which employ a total of 130 people. Of these employees, 73 per cent are women. A large number of volunteers - approximately 450 of them - also work in the Health Councils. The Councils provide a network for various health care agencies and services, working to develop balanced health care facilities.

It seems lately that each Council will be treated as a separate entity, given that hiring and supervision is done locally. If this is the case, few of the women employed in these Councils are likely to find male comparators. For example, in one city Council, there are 12 full - time employees; 3 men and 9 women. The executive director, the chairperson and one of the 3 permanent health planners are male while the assistant executive director, the 3 non - permanent health planners and the 3 clerical workers are all women. None of these employees belong to a union and none have formal, written job descriptions.

3. Laundries Operated Exclusively for Hospitals

We were unable to determine the total number of laundries or employees included under this definition.

The two large laundries we contacted served a total of 33 major hospitals and employed 450 workers. Close to 90 per cent of the employees in these two laundries are women and most of them are women who have immigrated to Canada from Italy, Portugal, or Greece. The small number of men are employed primarily to load trucks and do other heavy manual tasks, although some women also do this work. These loaders are paid more than the women who fold and iron. In one laundry this loading work will probably be defined as a male job class; in the other it probably will not. In the laundry where a male job class may be established, job evaluation will determine whether or not this job will be a comparator for women's laundry work.

In both laundries, unions represent all non - management employees, jobs are advertised first to union members and the same benefits are available to female and male employees.

4. Hospital Food Services - Ontario Inc.

Although we have made over a dozen phone calls in an effort to find out about these services, we have been unable to collect any information on them.

5. Toronto District Heating Corporation

This organization supplies and manufactures steam for teaching and other metro hospitals. Although 50 people work in this organization, only two of them are women. One of the women serves as office manager and she is under contract from a consulting firm. She in turn pays the other woman who works as a secretary. Therefore, both these women are not likely to be considered employees in this establishment. Both women are paid more than the men who work as stationary engineers.

The men belong to either the International Union of Operating Engineers or the Canadian Union of Operating Engineers. Although these unions would negotiate a Pay Equity Plan, such a plan is unlikely to require payouts, given that there are only male job classes.

6. Addiction Research Foundation

The Addiction Research Foundation employs a total of 774 people, 64 per cent of whom are women. The staff is highly educated. For example, 23 per cent have master's degrees or higher and 12 per cent have Bachelor's degrees.

In the Executive Branch, 13 of the 15 people are women although only 3 women are in senior management. Women also dominate corporate communication, accounting for 75 per cent of the jobs. The work in Organizational Development is evenly divided between a woman and a man but in the Administrative Division, all 75 tradespeople are men and all 100 clerical workers are women. Of the broadly defined job classes that could be grouped together under these executive and administrative divisions, only the trades job class is male dominated.

In the Research Division, women make up 59.2 per cent of the employees. Whether or not female dominated job classes will be found in this division will partly depend on how jobs within research are classified.

Women dominate most jobs in the Clinical Institute which is part of the foundation. With 68 per cent of all jobs, they dominate the RN, therapists and RNA categories. They account for only half of the laboratory technicians and the doctors, however.

In the treatment school, women also hold over 60 per cent of the jobs. Here, too, job classes will depend on how jobs within the school are defined.

Those who work for the Foundation as community consultants or social workers are located in 29 centres throughout Ontario and it is not clear whether or not they will be defined as part of the Addiction Research Foundation establishment. They are paid by the Foundation but are not in the same geographical area. Over 60 per cent of these employees are women but we were unable to determine what proportion of the two different job categories included here were women.

Both laboratory technicians and the registered nurses are unionized but the majority of employees do not belong to a union.

A management consulting firm has classified jobs and placed them in a pay grade. A Pay Equity Plan was put into effect July 1, 1986. A classification committee has been meeting to review job descriptions. All non- unionized staff has been evaluated on the basis of the Curry - Cooper

Universal Point Evaluation System. Wage rates were not available to us so that it is impossible to predict whether or not the 495 women working for the Addiction Research Foundation will have higher wages as a result of Pay Equity. Much will depend on how the trades male job class is evaluated in comparison with the other job classes.

7. The Operators in Ontario of the Canadian Red Cross

The Red Cross in Ontario consists of a Head Office in Ottawa, a Division Office in Toronto and about 150 Branches throughout the Province. There are also 5 Centres for Blood collection and distribution.

We were unable to obtain figures on the number of employees in the Head Office. The Division Office employs 601 people, 50 of whom are men. Some of these employees are not physically located in the Division Office but they are directed and hired from Toronto. It is not clear whether those located in the Branches but hired in Toronto will be part of the Toronto establishment.

A significant proportion of the staff does clerical work but some are health care providers. The large number of homemakers who provide 814 000 visits to 100 000 Ontario homes are not included in this list of employees (Tiffany, 1988). The Red Cross is the largest provider of homemaker services but it is not clear whether these homemakers are employees of the Division or Branch Offices. It has been argued that they are self - employed, offering independent services to the Red Cross.

Three unions organize Red Cross workers. These are ONA, OPSEU and the Canadian Red Cross Blood Services Union. The latter includes clinical workers and drivers. OPSEU represents the technologists and ONA the

Registered Nurses. Most of the unionized staff are located in the Centres and each bargaining unit negotiates with the Head Office for each Centre.

Men are scattered throughout the institution although the majority are found in management or maintenance. Maintenance is clearly a male job class and the following jobs are done only by men: building superintendent, commissioner, cook custodian, coordinator of full development, driver, warehouse person, handyman driver, first aide CPR instructors, payroll clerk, promotion and fundraising clerk, recruitment coordinator, supervisor of buildings, purchasing and warehouse.

We were unable to obtain full wage details. We did learn that the female accounts payable clerks ($21,084 job rate) and medical secretaries ($23,585 job rate) earned more than the male warehouse person ($21,456). Without more data, however, it is difficult to tell whether the more than 500 women who work in the Red Cross Division Office will find male comparators. If homemakers are considered part of each Branch or as self-employed workers, they will find no comparators and their hourly rate is unlikely to be raised from its current $5.00 level by Pay Equity.

8. The Hospital Council of Metropolitan Toronto

The Hospital Council of Metropolitan Toronto is a voluntary organization which serves, according to their brochure, "the diverse needs of the Metropolitan Toronto hospital community". The membership includes the University of Toronto Health Sciences Division and 40 acute care, rehabilitation, convalescent, chronic and specialty hospitals within Metro. Some hospitals in surrounding communities hold associate membership. In total, member institutions account for "approximately 20 per cent of the hospitals in Ontario and 35 per cent of the provincial bed total". HCMT coordinates shared services, collects data on and for members, serves as an advocate and represents members in relations with the Metropolitan Toronto District Health Council. Although the HCMT does an annual survey of salary levels, this was not made available to us.

The HCMT employs 9 people full - time. There are two clerical and 7 professional or management staff. No sex breakdown was provided. The HCMT is developing a Pay Equity Plan.

9. The Hospital Medical Records Institute

Founded by the Ontario Hospital Association and the Ontario Medical Association, this not-for-profit, federally-chartered company provides information services to hospitals, government and doctors. When patients are discharged, records on their length of stay, the diagnosis, the services used and the tests done are sent to the Institute.

Of the 37 people employed in the Institute, 30 (81 per cent) are women. The finance and administrative staff includes a secretary/ receptionist, 2 secretaries, a bookkeeper, 2 people in charge of finances and 5 senior administrators. Of the rest, 10 work as health records technicians, 10 as computer program analysts and 7 as computer operators. No information was provided on the sex of employees in each job class, although most jobs outside senior administration must be female dominated. None are unionized.

10. The Ontario Cancer Institute

The Ontario Cancer Institute is the legal entity responsible for the Princess Margaret Hospital. Affiliated with the Ontario Cancer Treatment and Research Foundation, it treats cancer patients , does research on cancer and trains people to treat cancer. The 1500 employees mainly work in the hospital and will be included in hospital statistics.

11. The Ontario Cancer Treatment and Research Foundation

The Foundation operates 8 regional cancer treatment centres that are affiliated with hospitals and 17 clinics which follow up on patients and offer consultation services. The statistical section compiles data on cancer cases and 5 lodges provide accommodation for ambulatory cancer patients who are from out-of-town.

It employs a total of 1,529 people, 78 per cent of whom are women. Of these employees, 306 are classified as casual and may be excluded from the Act. Women account for 85 per cent of the 1,223 regular employees. While information was not available on the sex composition of the workforce in these centres, few male comparators will be found if the clinics are similar to others we examined.

12. The Ontario Mental Health Foundation

The Foundation is responsible for administering 3 million dollars in research grants. The Foundation provides funds for research on mental illness and also organizes an education program to inform people about the impact of their research.

Governed by a lay board which is appointed by Order - in - Council, the Foundation management consists of a male executive director and a female director of finance. The rest of the staff, which includes a bookkeeper, 2 secretaries and a clerical worker, are all women. Salaries are reviewed each year by an executive committee. There are no male comparables for the 4 member non - management staff.

13. The Toronto Institute of Medical Technology

This is primarily an educational institution. According to the Executive Director, it employs between 130 and 140 people full - time and 2 to 3 part-time staff. Of these, 39 are faculty and the rest are management and administrative support staff. Approximately 70 per cent of those who work for the Institute are female and there seem to be no male job classes. While the Institute also employs a large number of staff for the continuing education program, these people will probably be defined as casual employees and thus will not be subject to the legislation on Pay Equity.

The faculty belong to OPSEU but other employees are non - unionized. Two different job evaluation schemes are in use. The Hay system is used to evaluate jobs in senior management and the Towers, Perrin, Forester and Crosby scheme is employed for other staff. The management is working with OPSEU on a Pay Equity Plan.

Community Health Program

Health Service Organizations

There are 34 Health Service Organizations in Ontario. The ministry does not have a record of the total number of employees, in part because all staff are employed directly by each HSO. It seems likely that, if each of these organizations is treated as a separate establishment, most of the women working in HSOs will not find a male comparator.

For example, in one city HSO, there are 7 employees. Only one male works in this Service. He is one of the two doctors. The administrator and her assistant, the massage therapist and the two receptionists are all women. Another male doctor works in the Service part - time and is paid directly by the Ministry. No staff belong to a union.

Community Health Centres

There are 17 Community Health Centres throughout Ontario and the total number of staff employed in these centres is not available. Each Centre does its own hiring and thus will probably be treated as a separate establishment. In some of the large Centres, women may find a male comparator.

For example, in one city Health Centre, 3 of the 17 employees are men. Two of these men work as physicians and are unlikely to be used as comparators, especially given that there is a third doctor who is a woman. The male bookkeeper, however, may provide a comparator for the two female receptionists and the female medical secretary. The 2 nurses and 2 nutritionists, the psychologist, case manager, senior's community worker, the health promotion coordinator, the executive director and the administrative assistant - all of whom are women - will have no comparator. None of the staff belongs to a union.

Other Establishments

Hospitals

The most important employer in the health sector is not included in the appendix. There are 249 hospitals in Ontario. Of these, 222 are Public, 18 are Private and 10 are Provincial Psychiatric Hospitals.

The Ministry of Health does not keep data on the sex and number of employees in hospitals. However, a Workforce Survey (Ministry of Health, 1987) of Public Hospitals found that 84 per cent of the 136,293 employees are women. Women account for 98 per cent of RNs and 97 per cent of Secretarial and Clerical staff. Men, on the other hand, hold two - thirds of the senior management positions. Table 10 graphically illustrates the sex segregation and greater detail would probably indicate greater segregation. Men are found in management, maintenance and trades. Women do everything else. Proportions varied somewhat with the size of the hospital. Specialty Hospitals had more women in senior management and small hospitals had a higher proportion of women in service jobs.

There are, as mentioned earlier, 6 major unions in the hospitals. While the proportion belonging to a union is higher than in other sectors of the economy, the majority of women are without union representation. Many of the larger hospitals will have to juggle 12 or more Pay Equity Plans.

There were significant variations in salaries. While 21,630 men work in Public Hospitals, 1,222 are paid $42,000 a year or more. At the same time, only 746 of the 114,663 women employed in hospitals are paid $42 000 or more. Although 12 per cent of women earn less than $18,000 a year, 6 per cent of men are in this range (Calculated from Ministry of Health, 1987: Table 11a). The lowest salaries go to the women doing clerical and service work.

Male comparators for the service workers may be found among the maintenance staff. Except in large hospitals, women therapists, technicians or technologists, RNs and RNAs are unlikely to find male dominated classes that are paid more but that are judged of comparable worth.

Registries

Private registry services are growing rapidly. These services find temporary jobs for a wide range of health care workers. There are no data on the total number of employees or their wages. Some Services are operated as cooperatives or as agencies that provide a service to self - employed workers. Some are direct employers.

Some pay rates higher than those offered to regular staff, some pay much lower wages. Wages are "set by the marketplace", according to one employer. Very few registries offer benefits to employees and none are unionized.

It is unclear how they will fit into Pay Equity but very few will have male comparators in any case.

Conclusion

This profile is far from comprehensive but it does offer an indication of the complexity of the industry and of the difficulties involved in applying Pay Equity in this sector. An educated guess would suggest that only a minority of women will find male comparators and receive wage increases under the current Pay Equity Act.

Chapter 4

Profiles of Health Care Establishments

Based on the available data, the previous chapter offered a broad outline of the health care labour force in Ontario. A major problem with these data is that they tell us very little about who will benefit from Pay Equity and who will not because the Act does not refer to the labour force in general but rather applies to particular establishments.

In order to get some indication of how the Act will work in individual establishments, we visited a range of health care institutions and drew up the following profiles which outline the probable impact in each case. These are examples, rather than samples, of health care establishments. They are based on documents provided by the institutions and on interviews with a small selection of personnel. They are presented in order to help develop a picture of the possible benefits and problems in the legislation. They are in no sense designed as blueprints for the application of Pay Equity.

Profile of a Large Urban Hospital

This major metropolitan hospital employs approximately 2,600 people to service close to 600 beds. A third of these employees work part-time. Seventy-nine percent of the full-time employees and 83 percent of the part-time employees are female. Women account for 80 percent of the total workforce. Money for this public hospital comes primarily from the government, although some public fundraising is done for capital expenditures or other expansion programs.

Establishment

The hospital constitutes a single establishment although there may be some confusion about affiliated organizations.

Employer

The hospital board is ultimately responsible for the hiring, firing and disciplining of most of those involved in providing care. Not all the people who work in the hospital are employed by it, however. Many doctors are not considered employees and the nurses or receptionists who work for them are employed by the doctors rather than by the hospital. Some services, such as part of the cleaning, are contracted out to other employers. Others, like the gift shop, are operated by volunteers. Some temporary workers are hired through personnel agencies. Many more than 2,600 people, then, work in this hospital but they will not be considered in the hospitals pay equity plans.

Bargaining Units

There are 5 unions and 8 bargaining units in this hospital. ONA bargains centrally for 487 full-time nurses and 361 part-time nurses. OPSEU, too, bargains centrally for its 164 members. SEIU bargains centrally for 336 full-time workers and locally for part-time workers. SEIU also bargains locally for 256 clerical workers. The Association of Allied Health Professionals: Ontario bargains locally for 77 employees and so does the International Union of Operating Engineers for its 20 members. In other words, there are 4 centrally bargained and 4 locally bargained collective agreements covering a total of 1868 employees, or 84 percent of the labour force.

There could then, be 9 pay equity plans. Some of them will have comparators within their unit; some will not. No strikes or lockouts are permitted.

Job Classes

According to the consulting firm that studied this hospital to determine the possible impact of various pay equity schemes, there are at least 16 female dominated and 14 male dominated job classes. Female job classes under this scheme included: various clerical categories and some management jobs, technologists, head nurses, registered nurses and registered nursing assistants as well as therapists and housekeeping aides. In 10 of the 16 categories, only women were employed and women accounted for more than 90 percent in 4 of the other 6 jobs. The two remaining technologist categories were more than three-quarters female.

Of the male dominated jobs, all but one was entirely male. These included engineers, carpenters, mechanics, butchers, hospital assistants and patient porters, electronic technologists, prosthetist orthotists, purchasers, managers, "professionals" and purchasing agents. The only category that included women was system analyst and two-thirds of those employed in this work were male.

While this scheme does not cover all jobs in the hospital, it does indicate the clear sex segregation within this institution. Other data supports this conclusion. Excluding those who work as doctors, 9 percent of the men employed in this hospital work in middle or senior management compared to 3 percent of the women. Men's average salary is higher than that of women even though 44 percent of the women work as nurses and 34 percent of the men work in dietary, housekeeping or other services. Women are outnumbered by men only in the trades and maintenance jobs although men do account for 40 percent of the senior and middle management. Segregation is also evident within job categories. Of the 8 men in supervisory jobs, for example, one-half are paid at the top of the salary range while only 28 percent of the female supervisors are paid at this rate. Because there are large numbers of employees in most categories and because there are consistent divisions by sex, the sex composition of most classes should be relatively simple to determine.

There may still, however, be questions related to how a job class is defined. Do, for example, the 8 grades of clerical workers whose starting wage ranges from $9.26 per hour to $11.56 per hour constitute a single class because they have a common wage scale and similar recruiting procedures or will the differences in qualification, duties and responsibilities be sufficient to constitute each grade as a separate class? Are the differences in wages, qualifications and duties among technologists and therapists sufficient to constitute each of them as a separate job class? In the case of unionized workers, this will have to be determined through negotiations. For the 352 non-unionized people who work in the hospital, categories will be defined by the hospital plan.

Wage Rates

The wage rates and benefits for the non-unionized employees are not available but those for the 84 percent of the workforce that is unionized are established by the collective agreements. These rates suggest that there are significant differences between female dominated and male dominated jobs. Taken together, the average annual wage for women in the female dominated jobs selected by the consulting company is $25,630; the average for men in the male dominated jobs is $30,853. This is the case even though the largest categories in male jobs were hospital assistant and patient porter while the largest female categories were registered nurses and ward clerk receptionist.

Taken individually, the differences are also evident. For example, the average annual salary for a male patient porter is higher than that of either a female housekeeping aide or of a ward and a grade 3 clerk. A male assistant purchaser has a higher annual salary than a registered nurse and a butcher is paid almost $6,000 more a year than a registered nursing assistant. The female dominated technologist category has an average annual salary of $30,000 compared to a male electronic technologist who averages $33,300 a year. There are also wage and benefit differences between part-time male and female employees as well as differences between those who work full-time and those who work part-time. The majority of part-time employees are women.

Supplementary unemployment benefits are available to many unionized workers taking maternity leave and credit for competitive seniority accumulates during this leave.

Many jobs must be advertised to union members before a public advertisement appears and many jobs are regularly evaluated although none of the unionized jobs, as far as we could discover, are eligible for merit pay.

On the job training is frequently provided and some educational leave is available to many unionized workers. However, these extra skills are seldom recognized in pay. Most promotions depend on employees leaving the system for major retraining. Many jobs are regularly evaluated.

Comparators

ONA, and perhaps AAHPO and IUDE, may not have any comparators within their bargaining unit given that the overwhelming majority of nurses are female and so are a high proportion of dieticians, therapists and technologists. Most operating engineers are men. As is the case with any pay equity plan, the development of comparators will depend on both the determination of job classes and the evaluation of jobs. If existing job descriptions are used, then many jobs may not find a comparator.

For example, the consulting firm suggests that there will probably be no comparators for housekeeping aides. The job descriptions for the male porter and the female housekeepers indicate major differences, yet the jobs are basically similar. He mainly cleans floors and walls in corridors; she cleans patient rooms, wards, nursing stations, lounges, laboratories, bathrooms, offices and like the man, "other areas assigned". He uses 20" rotor, automatic floor machines, commercial vacuums, 24 oz. wet mops, large wringers and "other necessary equipment"; her tools are smaller and she doesn't get to use the automatic floor machines but she also must use "other necessary tools". Both have to pass physical examinations and while she must "demonstrate the correct use of chemicals, supplies and tools", he must "pass a test of skill and mechanical aptitude to detect equipment malfunctions". He also has to be able to climb ladders. Yet he is not expected to fix equipment and both are expected to "observe and report the need to repair" equipment or furniture. The basic differences between the job descriptions then are related to his use of floor machines and her work in a wide variety of areas. Traditionally, it has been argued that cleaning floors with machines takes greater skill and effort than cleaning bathrooms and patient rooms with a range of special cleaners.

The actual descriptions of their daily work, however, suggests that the male dominated and more highly paid job does not require more effort, skill, or responsibility. Nor does it involve inferior working conditions. Indeed, the reverse may be the case. She cleans "the nursing station, cleans utility room, dirty utility room, classroom, office and 17 patient rooms...This includes high dusting, baseboards, sweeping and washing the floors...If we are short-staffed I also have to clean 4 more patient rooms, the T.V. room, 3 more offices and the public washroom. The work is really busy, you keep going all the time, sometimes it is really hectic. The work is hard on the back; the mopping, sweeping and cleaning. My knees also get sore. There could be other hazards also...if the proper isolation signs are not on the door. One time, I had cleaned a patient's room for a week before I found out he had T.B....When we see an isolation sign on the door, I just ask the nurse what I have to wear. Sometimes I need gloves, mask and gown, and other times I just need a mask or gloves. But I wear gloves all the time. I think it is safer, and the cleaning fluid bothers me after a while, so I just leave them on". According to the male porter we interviewed, these women also have their work checked much more closely than the men, increasing the pressure under which they work. She works "7 a.m. to 3 p.m., with every second weekend off".

The male porter's description of the job did not indicate that it was significantly more onerous or that it required very different skills from the work done by the women. In fact, he pointed out that the "men cleaners used to dust-mop and wash the floors but now the women do it. Now all the men do is dust and mop the corridors and buff the floors." He went on to explain that the "new machines aren't hard to use but they don't get into the corners". He damp buffs and shampoos the carpets in doctors' offices, clinics and the residents' sleeping room so he is rarely exposed to patients and their illnesses although he was once pricked by needle left in a clinic. He also dusts and mops corridors and takes out the garbage. "Most days I help moving furniture...mostly dishes...the fellow calls me if he needs my help". Large moving jobs are done by contractors. He works Monday to Friday, 7 a.m. to 3 p.m. He used to work on patient wards: "I hated working there. If a patient messed on the floor, the nurses would call one of us to clean it up...and we're not supposed to do that". He thinks that it is fair for male cleaners to be paid more because "the male has a family to support", not because their work is significantly different.

A female dietary aide also makes less than a food service porter. Yet for the women we interviewed, the jobs involved "lifting large pots filled with ice" and collecting trays that are "very heavy to carry, especially if you are carrying more than one at a time. The floors are constantly wet in the dish room where the trays are emptied and washed. Even though we have mats, it is very slippery and dangerous. At the beginning and the end of the belt, there is a lot of heavy lifting...putting trays on and taking them off the belt. Women usually do this job. Aside from the lifting, the job is quite stressful. You have to keep up a good speed. The room is very crowded and it becomes really hot, particularly in the summer. There are some days in the summer, particularly one like this year, when the temperature has reached 140 degrees F." And there is no job to move into if she works hard because "nobody in the department really gets promoted. If a supervisor's job comes up, they hire someone from outside".

A clerk-receptionist, paid less than the male porter, described her day as follows:

"At 8 I do rounds in the unit, to check for any admissions or discharges from the night before, and record them all. There is no clerk between 11 p.m. and 8 a.m. during the week, and only one day clerk on weekends. Therefore all the paper work not done on these shifts has to be caught up. Every day has a different routine...for example, Monday is supply-ordering day. We have to order paper supplies and desk items. The phone rings very often... we have to answer all calls. Many of these calls are patient inquiries, so we have to find the appropriate nurse to talk to the family...As well, we greet the visitors and direct them to the appropriate room. We are also responsible for doing the payroll, filling out work orders for maintenance, and call for repairs. We do some typing, again, depending on the needs. We also keep track of...compile statistics on the type of admissions, how long their stay, etc. We fill out diet slips, and order diet changes. We prepare the patients' charts for admission, transfer and discharge. The job can really get quite hectic...especially if there are two patients being discharged, and three being admitted. You need a lot of patience. Sometimes we get really busy, but you can't take it out on the patient's family...just because they happen to arrive when it is most busy. You also get used to working under pressure. Organization is also very important. You have to priorize the jobs...so many things to be done at once. After working here for 1 month, I started to feel comfortable. You also have to be very accurate and careful, making sure the correct lab result is attached to the proper chart."

She works shifts and does different tasks then. She finds it difficult to phone relatives of dead patients to ask them to pick up belongings, a frequent task in this unit.

A registered nurse who makes less than the pay in 8 out of the 14 male dominated jobs identified by the consulting companies, outlined some of the invisible skills involved in her work:

"You need to be organized, because things can change so suddenly, and you have to be prepared to cope with the change. You also have to be patient. The patients in the unit can be very confused...often they are thrashing, hitting, etc. It is also difficult to deal with families who are constantly phoning for information. What we do is ask the family to name a spokesperson, and only that person phones...and he or she lets the rest of the family know. Tact is also important...particularly helping families through the grieving process. Learning to cope with frustration...some doctors don't listen, or take recommendations to heart. You often have to wait for equipment, or it doesn't work...everything often seems to take too long. Even just the job of changing linen on a bed...you often can't do it alone...too many attachments...so you try to find help, but everyone is busy, so you wait till they are finished...so much time is wasted."

Although many female job classes are paid less than many male job classes, it is not clear that they will all benefit from pay equity. The women who work at higher levels are more likely to have skills similar to those of men and skills that can be more easily quantified by current job evaluation schemes. The job description of a clinical pharmacist, for example, is carefully detailed and lists a wide range of specific, easily measured skills while that of the clerk receptionists is shorter and focuses more on duties or specific tasks. As one person we interviewed pointed out, these job evaluation schemes have been mainly developed for men in business; not for women in health care and support seldom counts.

Pay Equity Plans

The hospital has completed, in conjunction with the union, some job evaluations and evaluations of non-union jobs have been done according to a consulting company plan.

It is impossible to predict how many women in this hospital will benefit from Pay Equity because the number of variables involved is so large. However, women who work in such a large health care institution have the best chance of receiving wage gains from pay equity, because they are in the best position to find a comparator. While the two ONA bargaining units in particular will not have comparators within their unit, they should be able, unlike nurses in smaller hospitals or in clinics and agencies, to find comparators within the establishment. Much will depend not only on how jobs are classed and defined, but also on who falls within the other bargaining units.

Profile of a Small Rural Hospital

This hospital falls into the under 49 bed category, providing both active and chronic care in a twenty-five bed facility.

Establishment

The hospital is a clearly defined establishment, confined within a single building.

Employer

The Board of the Hospital has the right to hire, fire and set conditions of work. The hospital does not contract out for services although supplementary services are provided by the local Public Health Unit and some construction related work is done by contractors. Doctors' offices are located within the hospital, and these doctors pay for the services of two receptionists who are not hospital employees.

Bargaining Units

There are three bargaining units in this hospital. All the registered nurses belong to ONA although there are separate collective agreements for full and part-time nurses. The service employees, including admitting clerks, kitchen and housekeeping staff, RNAs, ambulance drivers, one maintenance worker and a part-time physiotherapist belong to CUPE. All three collective agreements state there will be no strikes or lockouts.

There are, however, 16 people employed by the Hospital who do not belong to a union. In addition to the administrators, supervisors and their clerical staff, this group also includes those who work in the labs, in records and in physiotherapy. One maintenance worker, who as of this year supervises another maintenance worker, is also outside the CUPE bargaining unit.

There are then, three collective agreements and one group without a collective agreement, leaving the possibility of four different pay equity schemes.

Job Classes

There are written job descriptions and established wage scales for both union and non-union workers. This should simplify the determination of job classes. However, several factors may complicate this process. Different contracts for part-time and full-time nurses suggest that each may constitute a separate female job class. Similarly, it may be argued that part-time and full-time laboratory and x-ray technicians have different responsibilities and therefore fall into different job classes. On the other hand, it may be argued that all technicians—whether they are laboratory or x-ray—have similar wages and should constitute a class. If technicians are grouped together, then it would be clear that this is a female job class. If they are separated, then there would be some question about laboratory technicians, given that one of the two is a male.

Only 9 of the 62 employees are male. Two of these men do maintenance work and there can be little question that this is a male job class. The administrator and the director of services are also male, although this has not always been the case. There may then, be an issue as to whether or not these are male jobs. Four of the men work as part-time ambulance drivers but, because two women are also employed as part-time ambulance drivers, there may be a debate about whether or not part-time ambulence drivers constitute a female job class while full-time drivers are in a male job class. This work has traditionally been done mainly by men. One of the two laboratory technicians is also a male, creating another problem in terms of determining whether or not this is a female job class. It could be argued that this has traditionally been women's work.

We are left, then, with one clearly established male job class in this hospital--maintenance work. Even this job, however, may be divided, given that one maintenance worker is a helper and the other is described as a supervisor. With the exception of ambulance drivers, administrators, maintenance workers and perhaps lab technicians, all other jobs are done entirely by women.

Wages

Wage rates for CUPE members are based on the mean rate for hospitals with less than 49 beds and nurses receive the ONA provincial rate. The male maintenance helper earns more than everyone within the CUPE Local except the RNAs. In other words, he earns more than the admitting clerks, the dietary aides and cooks, the laundry and housekeeping staff, the women in central supply and the ambulance drivers.

The male maintenance supervisor, who is responsible for this one male helper, is not a member of the union. He earns more than all CUPE members, including the RNAs. He also earns more than the non-unionized secretary, medical records clerk and the dietary supervisor--all of whom are women.

Comparator

Whether or not male comparators are found will depend both on the problematic decisions about job classes mentioned above and on the evaluation of jobs.

If current job descriptions are used, it seems unlikely that many of the female job classes will be judged comparable to existing male job classes. Under current job descriptions, for example, the maintenance helper/cleaner "must be physically fit; capable of lifting; works inside and outside in all weather; may have to work in awkward positions; subject to burns; cuts and falls; must be able to stand, walk, stoop, kneel, bend and climb." Yet the job description for the dietary aide who earns less than the maintenance helper, does not mention that she too is subject to burns, cuts and fall, must stoop, bend and even sometimes climb in order to unpack, store, and prepare food. Similarly, the maintenance supervisor's job description emphasizes that he "directs heavy custodial duties such as storage and cleaning outside windows, changing screens and storm windows, changing light bulbs in ceiling fixtures and housekeeping duties in very high places" but words such as heavy do not appear in the description of the work performed by the dietary supervisor, even though she has to handle all the supplies. While the dietary supervisor "supervises all staff", the maintenance supervisor "orients, instructs and supervises other maintenance personnel, assigns duties and evaluates work performance". It should be noted that the more highly paid maintenance supervisor does all this for one helper and the dietary supervisor is responsible for two full-time and two part-time employees who work in the kitchen. In addition, the dietary supervisor gives dietary advice to patients in and out of the hospital. Moreover, an "understanding of French" is "beneficial in her job" but is not mentioned as helpful for maintenance. But she still gets paid less.

A gender free job evaluation scheme that took all activities required of workers into account could mean that all members of CUPE (with the exception of the RNAs) and many of the non-unionized clerical staff would have their salaries raised to the level of the maintenance helper and that the dietary supervisor at least would have her salary raised to that of the maintenance supervisor. The non-unionized workers, however, may not be able to use unionized workers as comparators.

There appear to be no comparators for the nurses and technicians unless they too argue that they have responsibilities equivalent to those of the maintenance supervisor or the director of services. This, of course, would require going outside their bargaining unit.

Pay Equity Plans

This hospital has been participating in workshops on Pay Equity organized by the OHA and is awaiting the recommendations of the OHA on how to proceed with job evaluation. All employees should fall under the Act, and none should be classified as exemptions although it may be argued that the salary for maintenance workers reflect shortages. A new job evaluation scheme could mean significant gains for many of the lowest paid workers in and out of the union. On the other hand, if the employer continues to argue that each of these male maintenance workers "does a little extra", as one employee reported, then there could be no adjustment for the 53 women who work full or part-time in this hospital.

Profile of a Psychiatric Hospital

This psychiatric hospital offers a wide range of services in an urban location. It employs approximately 500 full-time and 320 part-time personnel, although numbers vary from week to week.

Establishment

An independent hospital that hires its own staff, this hospital will constitute a single establishment.

Employer

The employer in this case will be the Hospital Board. As is the case in other hospitals, however, some personnel are hired from registries when there are shortages and some services provided within the hospital are purchased from outside agencies. The personnel employed in this manner will not be considered employees of this establishment.

Bargaining Units

About half the employees are unionized. ONA represents approximately 98 full-time and 100 part-time nurses. Their separate contracts are bargained centrally with other hospitals.

Those in housekeeping, dietary, maintenance and trades as well as RNAs and psychiatric assistants belong to the SEIU. This union bargains for wages at the local level.

Non-unionized workers include the clerical and technical staff as well as professionals such as social workers, psychologists, occupational therapists, pharmacists, research scientists. Paramedics are also outside the union.

Four Pay Equity Plans are therefore necessary.

Job Classes

As is the case in other hospitals, men are found at the top and bottom of the hierarchy and women are in highly sex-segregated jobs.

Women dominate the nurse therapy and most of the other medical jobs. All the RNAs, the pharmacists, and occupational therapists are women, as are the overwhelming majority of nurses and 60 percent of the Social Workers. However, all the psychiatric assistants, the biomedical engineers and the senior research scientists are male. In the case of the psychiatric assistants, it is not clear whether or not they will constitute a male job class for the purpose of Pay Equity because the Human Rights Commission has already stated that this group can be exempted in terms of male only hiring. As for the biomedical engineers and the senior research scientist, the person we interviewed said that "this is the one place we are vulnerable. In spite of much trying, we haven't been able to get females for these positions. As far as the legislation is concerned, comparison could be made with a head nurse". These three jobs are, according to Pay Equity, male job classes.

The 6 salaried psychologists are eligible for inclusion in Pay Equity Plans but the job is gender-neutral. There are 3 females and 3 males.

Women also dominate the clerical and service jobs. Although there are no male job classes within the clerical occupations, men are found in both housekeeping and dietary services in sufficient numbers to constitute, in some cases, male job classes. As one person we interviewed explained, "we suffer from the same problems faced by other institutions. The higher paying jobs in these areas are filled by men." The cook/bakers and the most senior cleaning workers are all men. All the maintenance workers are men.

Wage Rates

ONA wages are bargained centrally and follow the provincial rate.

The cleaner 1 and food service 1 jobs are paid between $9.75 and $9.84 per hour. The cleaner 2 and food service 2 are paid between $10.29 and $10.52 an hour. The male dominated cook and cleaner 3 jobs are paid significantly more: between $11.08 and $11.29 for the cleaner and between

$10.86 and $11.06 for the cook. This cleaner category is paid more than the RNA category which has a range from $10.85 to $11.09 an hour. These RNAs are also paid less than the all male maintenance workers who earn between $11.83 and $12.11 an hour.

The male biomedical engineers and research scientists are paid more than the all female occupational therapists but less than the head nurses. Yearly salaries for biomedical engineers range from $32,000 to $39,263; for occupational therapists from $30,672 to $37,297; for head nurses from $36,817 to $42,213.

Comparators

As is the case in other hospitals, the female dominated clerical and service jobs may find comparators within their bargaining unit by establishing the maintenance, cleaning 3 and cook jobs as male dominated. The outcome of these comparisons will, however, depend once again on how a gender free evaluation system is structured.

Although occupational therapists usually have more years of formal schooling and apprenticeship than is the case for many biomedical engineers, it is not clear whether or not an evaluation system will determine that these jobs are of comparable worth.

Unlike many other hospitals, this one has 2 male comparator groups within the other medical occupations but the effect of this comparison cannot easily be determined in advance.

Pay Equity

Although Pay Equity negotiations have begun, no agreements have been reached. The OHA has recommended an evaluation scheme but the unions have not yet accepted the recommended plan.

There are some male comparators within this hospital but here too much will depend on negotiation and the job evaluation scheme employed.

Profile of a Rehabilitation Hospital

This free-standing rehabilitation hospital functions as an intermediary step between treatment in an acute care hospital and return home. This 120 bed hospital is fully government funded. The overwhelming majority of the employees - 88 percent - are female.

Establishment

This independent hospital constitutes a separate establishment.

Employer

The employer of most people who work in this hospital is the Board of the hospital. However, both the pharmacy job and the homecare work are contracted out. Gardening is done by an independent firm and personnel are frequently hired from nursing registries and office personnel services.

Bargaining Units

There are two bargaining units in the hospital, with 64 percent of the employees unionized. Of the 87 nurses, 80 belong to ONA. CUPE represents two of the therapists, as well as dietary, housekeeping and maintenance staff. Three Pay Equity Plans are possible, one for each of the bargaining units and one for the non-unionized employees.

Job Classes

There are two male dominated jobs listed by the pay equity group at this hospital. All 3 of the people employed to do maintenance work are male and the staff doctor is also male. There are a considerable number of males employed in dietary and housekeeping work but both categories are over 60 percent female. However, within housekeeping the men are more likely to be classified as porters and the women as general housekeeping. Similarly, within the dietary category, more men are likely to be porters and more women general help. In each case, there are different wage rates for porters and general help. All other job categories outside those classified as management are overwhelmingly female dominated.

Three of the 4 managers of dietary work are male and men are managers in housekeeping and maintenance. There are also two male senior administrators and one male middle level administrator. In other areas, the majority of administrators are women.

Wage Rates

The employer has established wage rates which indicate that the male maintenance workers who make between $11.00 an hour at level 1 and $11.41 an hour at level 2, are paid more than the women who work in housekeeping, dietary services or who do clerical work and more than all but one level of aides.

Management wage rates were not available. Benefits are established for the unionized workers in their contracts but we could not find out about the range of benefits available to non-unionized employees. The hospital pays for half the cost when therapists attend seminars and time off is allowed for one course. The therapists indicated to us that they use their own money and vacation time for other courses. As is the case in other hospitals, extra courses are seldom recognized in pay and there are few opportunities for promotion without major retraining outside the hospital.

Comparators

The nurses in ONA will have no comparators within their bargaining unit and it is difficult to find a comparator outside the unit, within the establishment.

The housekeeping, dietary, clerical and aide job classes may be able to establish that a gender free job evaluation would indicate that their level of skill, effort, responsibility and working conditions are at least equivalent to those of the lowest level maintenance worker.

The woman who works in health records, for example, gets headaches from watching the VDT, and her neck hurts from typing. "Some days I have a whole bunch of coding to do and I have to spend hours on it. Actually, I just take a break every now and then because I would get headaches." Like a maintenance worker, she lifts heavy boxes of records and puts them on shelves. A range of skills are required. She has to know medical terminology and how to code this on the computer. She is "responsible for all the charts of the previous year, including the ones on microfilm." All this information must be kept confidential, an added responsibility.

The engineer listed on the wage scales is also classified as maintenance and he is paid an hourly rate of $21.33, over $2.50 more than the highest paid therapist.

Yet therapists complete 4 years of university and an internship. They need considerable interpersonal skills to deal with patients and co-workers. According to an occupational therapists, "we work with a team, we work a lot with the physiotherapists because we complement their treatment. We work with all the nursing staff--the Unit Managers, the RNs and the RNAs and then we might work with housekeeping because they may translate for us." We often have contact with the family and social services who find placements for patients after they leave the hospital. We deal with the patient's former employer or school or university or wherever they may go back to. We often have to see 4 or 5 patients at the same time...You feel like an octopus sometimes. You coordinate with other O.T.s, deal with doctors--legally they have to ask for our treatment. We have to motivate for the things a doctor may not have thought of. We also coordinate with government bodies--like Ontario Assistance Device Programme. We have to explain why a person needs a device like a wheelchair, fill out forms and make phone calls. We also coordinate with manufacturers of wheelchairs to find out what's on the market, what's coming up, what's available and we order the patient's equipment." She finds it a "very tiring job. Physically and mentally it's very tiring, especially if you have a demanding family...Patients can refuse treatment and you have to motivate them to come and they can be rude and very angry with you. And also physically, you might get hit by someone." Some areas are particularly difficult. "We have to talk about sexual issues, especially with married men and that can be quite embarrassing if they don't see it as a professional thing and they start to make comments and make overtures and that kind of thing. Also, bathing and dressing and practicing those things can be quite embarrassing if they don't see you as a professional but as a woman. We are not nurses. Nurses are kind of lucky--they have a kind of aura about them--that's a nurse--but because we are not doing the same things then we get some of the flack. Whereas a nurse wipes a patient's bottom, we have to teach patients how to wipe their bottoms".

A physiotherapist feared that the repetitive motions required of her when she gives treatments are stressful on the body. She also expressed a fear of getting AIDS from working with patients in the pool. The urine, blood (especially menstrual blood) and semen could, she felt, be dangerous.

If, however, these therapists are unable to establish their comparable worth with the engineer, they will be unlikely to find another comparator within this establishment.

Because wage rates were not available, it is not possible to determine whether women in management will have male comparators who are paid more.

Pay Equity Plans

This employer has already established a Pay Equity Committee and hired a consulting firm to advise them on employment equity. If the women in housekeeping, dietary and clerical work are able to establish their comparable worth with maintenance jobs, then close to 60 women may benefit from pay equity. If therapists can establish comparable work with the engineer, then an additional 28 may see pay raises. If nurses too could prove that their worth is comparable to the engineer, another 87 would receive compensation. In other words, the majority of women would benefit from Pay Equity.

Profile on a Chain Owned Nursing Home

This 62 bed nursing home is part of a chain that operates facilities throughout Ontario and is licensed under the Nursing Home Act.

Establishment

It is not clear whether or not each nursing home is an establishment or whether homes within a geographical region will be grouped together for the purposes of pay equity. If homes are grouped together, more male job categories may be available for comparison.

Employer

There may be some debate about the employer as well. While each home is, according to the director, a separate unit responsible for the hiring and control of their employees, there is a regional director, and the head office bargains collectively with unions and does the bookkeeping. All salaries are established by the head office, although there are regional variations in wages. This could mean the development of a province-wide pay equity plan, taking into account all male and female dominated job classes in the province. On the other hand, it may be argued that each home must determine its own plan or do so with other homes in the region.

Bargaining Units

There are two bargaining units in this home. The RNs belong to ONA; the health care aides, housekeeping, kitchen and maintenance staff belong to SEIU. The administrator, the clerical staff and the RNAs are not unionized. Consequently, three pay equity plans could be developed for this establishment.

Job Classes

There are written job descriptions, established pay scales for unionized employees and few men, all of which simplifies the determination of job classes. All jobs are advertised in local papers after being posted for union members, although word of mouth fills most jobs.

Of the 48 employees, 3 are male. One of the 14 health care aides is male; none of the 12 part-time aides is male. While the health care aides clearly constitute a female job class, there may be some debate about the

RNA category. One of the two full-time RNAs is male, although both the part-time RNAs are female. This has historically been a female job however, and it should qualify as a female job class. With the exception of maintenance, all other jobs are performed by women. This includes 3 full-time and 4 part-time kitchen staff, a part-time kitchen supervisor, 3 housekeeping staff and a full and a part-time clerical worker.

It is interesting to note that the director of this home is a woman. She is also an RN. This was a major factor in her hiring because she often works as a nurse, given that this home now employs only one part-time and one full-time nurse to care for the 62 residents.

There is then only one easily established male job class; maintenance.

Wage Rates

The maintenance man is paid almost two dollars more an hour than the housekeeping and kitchen staff and significantly more than the health care aides. An aide is paid just under $425.00 for a 40 hour week and a dietary aide less than $420.00 compared to the $495.00 the maintenance man earns.

Nurses in this home are paid, according to one employee, between $1,500 and $2,000 a year less than hospital nurses. Salaries for the two clerical workers were not disclosed but if they are paid the average Ontario rate of $390.41 per week (The Management Board of Cabinet, 1988), then they too earn less than the maintenance man.

For unionized workers, benefits are similar regardless of job. No information was provided on benefits for non-unionized employees.

The only comparator in or out of the bargaining units in this home is the maintenance job class.

Comparators

It may well be argued that the women who are paid less than this job class have jobs that are at least equivalent in terms of skill, effort, responsibility and working conditions. All the health care aides in this home have their Health Care Aide Certificate, which includes as a requirement 325 hours of supervised nursing. As one aide explained, they do "back-breaking work". • Many of the residents "have very changeable moods, and we have to be really patient, especially with those who have Alzheimer's disease. Some are helpless, and we have to lift them dozens of times a day from their beds and wheelchairs to the toilet and the bath...we need big hearts as well as strong muscles to do our work".

The written job routine for housekeeping staff also suggests that these jobs require considerable effort and skill, even though these skills may not be recognized in a certificate. It should be noted, however, that the maintenance worker is not required to produce a certification of skills involved in the work. Both jobs involve heavy lifting, knowledge of materials, repetitive work, a variety of work sites and basic skills often thought to come naturally with the sex of the incumbent. Housekeeping staff washes floors, walls and windows; strips and waxes floors, cleans toilets, sinks and showers; washes and arranges furniture and organizes supplies.

The RNA and the nurses have no comparator, if comparisons are limited to this nursing home. Yet both jobs require at least as much effort as the more highly paid hospital work which may be allocated increases because comparators are available in those establishments. The RNAs in this home all have courses in drug administration, a policy of the nursing home chain.

The policy is necessary because with only one nurse in attendance, the RNAs do much of the work performed by nurses in hospitals.

Nurses, too, do different kinds of work than they would normally do in a hospital. As one nurse explained, they have trouble getting doctors to come, and therefore they have to take more responsibility for patient treatment. This nurse carried her own malpractice insurance to protect herself under these conditions. She was often called to help in the laundry or kitchen if other employees did not show up for work and was on one occasion called back to help mop up after a storm. She also acted as director when the director was not available, although this was not recognized in her pay. Work in this home involves more than 75 hours every two weeks and she carried a beeper in order to be on call. Limited resources meant nurses had to be very resourceful. The strain of the workload for this nurse means "there is burnout". Nursing home nurses are even further behind than hospital nurses in terms of pay and working conditions. These conditions may contribute to the severe shortage of nurses in this work and may lead, as the director of a hospital suggested, "to us searching for nurses in the Philippines".

More than half the women who work in this nursing home are bilingual. As the director explained, "all our French workers speak English". While bilingualism is not listed on job descriptions, both languages are necessary to do the work, given that half the residents at any one time may be French speaking. One aide speaks Cree, a valuable asset in a home that is providing care for 14 people who speak only Cree.

Pay Equity Plans

According to the director, she has no time to develop a pay equity plan and she knows of no other director who intends to do so. She is not aware of what the Ontario Nursing Home Association is suggesting as an approach to pay equity.

If this home is defined as a separate establishment with a local employer, then the only male comparator is the maintenance job class. If jobs are reevaluated for the purposes of pay equity, then the women who are dietary or health care aides and the women who do laundry and housekeeping, (that is, 37 of the 48 employees) could be eligible for increases under pay equity.

Profile of an Independent Nursing Home

This nursing home is an independent establishment run by a 5 member board for profit. Like other nursing homes, however, it receives much of its income from government subsidies and pension cheques. Although most of the residents are elderly people who require special assistance, there are also some younger residents who have no alternative to the nursing home.

Establishment

The establishment is easily defined as this home.

Employer

The employer is the 5 member board. Unlike many nursing homes, this one does not contract out for services but rather directly employs people to do the work.

Bargaining Unit

There are no unionized employees. Therefore, according to the Pay

Equity Legislation, the employer will prepare and post a plan. The employees will then have 90 days to review and submit comments on the plan.

Job Classes

Ten of the 91 employees are men. Put another way, 91% of the workers are female. Of the 10 men, one works as a bookkeeper, one as a cook, 3 as part-time dietary aides, 3 as maintenance and 2 as part-time receptionists. Maintenance and probably bookkeeping can be established as male job classes, given that only men do the work and these have traditionally been male jobs. Two of the 4 receptionists, or one-half of them, are male. However, this has traditionally been women's work and the one full-time receptionist is female. If full-time jobs are separated from part-time ones on the basis of salary scales, then receptionist would definitely be a female job class. All the full-time dietary aides are female, suggesting that this too is a female job class in spite of the presence of 3 men in part-time work. One of the two cooks is male and it is not clear that this job has traditionally or stereotypically been done by women in these institutions. Maintenance, then, is the only indisputable male job class in the establishment.

Volunteers also work in this nursing home and students from a local college do unpaid practical work here.

Although jobs have not been defined through collective bargaining, a consulting firm has drawn up job descriptions and wage scales have been developed for most jobs. Recruiting is done through newspapers, Canada Manpower and word-of-mouth.

Wage Rates

Most job classes have an established entry rate. After the 3 months probationary period, there are two increases a year until employees reach the four year ceiling. Each year the board of directors decides what the percentage increase will be. Although we were told that rates have to be comparable to union rates in other nursing homes, the starting rate for an R.N. is $2,00 per hour lower than the ONA hospital rate and there are similar differences between SEIU rates for dietary, housekeeping and health care aides in nursing homes and the rates given for this home.

The male bookkeeper, who is new to the job, is paid an annual salary of $20,000. The full-time female receptionist is also salaried, receiving $16,000 annually. Part-time receptionists of both sexes are paid $6.00 an hour.

In the indisputable male job class of maintenance, the supervisor is paid an annual salary of $30,000 and the other maintenance men earn $9.84 an hour.

Information on benefits was not available.

Comparators

As is the case in the other nursing home we examined, the administrator is a woman who has a nursing degree. While the other administrator was French-Canadian, this woman was born in Trinidad. A significant proportion of the employees were also foreign born. For example, a woman who works as a health care aide came from Barbados in 1969; a woman who works in the laundry left Greece 34 years ago; a housekeeping aide emigrated from the Philippines 13 years ago and the male cook was born in Guyana.

The exclusively female job of health care aide is paid a beginning hourly rate that is two dollars less than that paid to the maintenance men. These aides have taken courses in health care work and have received a certificate. They do morning care, breakfasts, baths and the toileting of patients. They make beds and clean toilets, tidy rooms and residents, put bibs on patients and feed them. All the time, they are providing comfort, chat and support. Their job means "we have to work together. This work calls for togetherness. We have a team. I am assigned to 10 residents. Out of the 10, 4 need more supervision than others...But my co-workers pitch in and help. If one of my residents has made a mess, co-workers don't wait for me to come back from lunch to clean up".

The female housekeeping aides also begin at hourly rates two dollars below that of the male maintenance workers. These women are "responsible for vacuuming, dusting and cleaning offices, residents rooms, halls and stairs". In each room they dust, mop, and wash the floor using a detergent/germicide. They also clean bathrooms. They are on their feet all day and wear gloves to protect their hands from cleaning chemicals. As one worker pointed out, "Sometimes if the nurses need help, I have to help them lift". She moves furniture and patients in order to do her work.

Contrast the work in these jobs to that of the job description for the assistant maintenance man. This more highly paid man is required to check call bells, appliances and the maintenance book, to set mouse traps, pick up garbage around the building, change light bulbs, check drains for problems, maintain lawns and shovel snow, vacuum elevator tracks, mop some stairs and paint if necessary.

Because a job description is not available for the male bookkeeper's job, it is not possible to compare his work to the job done by the female clerical workers. The receptionist in particular does a great deal of bookkeeping work in addition to operating the switchboard, monitoring and assisting residents as well as visitors. It may well be that this job class is comparable in terms of skill, effort, responsibility and working conditions to that of the more highly paid bookkeeper.

Pay Equity Plan

A management consulting firm has drawn up job descriptions which will likely provide the basis for the employers' pay equity plan. The clearly male job class of maintenance is more highly paid than at least two female job classes which may be judged comparable in terms of skill, effort, responsibility, and working conditions.

Compensation for others will depend both on whether bookkeeping is defined as a male job class and on how the female dominated clerical work is evaluated.

Profile of a Public Health Unit

This rural Ontario Public Health Unit provides an example of a situation where the application of the Pay Equity Act will be relatively simple and the impact of the legislation relatively limited.

Establishment

In this case, the establishment will be determined by the clearly defined geographic district for which the health unit is responsible. It covers a number of municipalities but jobs are defined, paid and supervised in a similar manner throughout the area. There appears to be little disagreement between unions and management on this issue. Although the money for the Health Unit comes from the provincial government, the unit is governed by a local Board of Health.

At first glance, there would seem to be one employer in this establishment, given that the Board of Health for the unit has been authorized to hire employees to provide services. Although the Unit does directly hire and supervise employees, it also contacts both the Victoria Order of Nurses and the Red Cross to provide services. There are then, really three employers within this establishment.

Bargaining Unit

There are two bargaining units in the establishment. All non-management employees directly hired by the unit belong to either the Canadian Union of Public Employees or the Ontario Nurses' Association.

Unlike the situation in hospitals, ONA has not established a provincial rate for their members working in Public Health Units so wages vary across bargaining units. Also unlike the hospitals, members of these unions have the right to strike. There is no centralized bargaining for Public Health Units.

With all non-management employees in just two bargaining units, the implementation of pay equity is simpler than it will be in establishments with more unions and with both union and non-union staff.

The people employed by the VON and the Red Cross, however, do not belong to unions. Employees of the VON belong to the Registered Nurses Association of Ontario but not to ONA. The RNAO does not bargain for nurses. The home care workers employed by the Red Cross in this area do not belong to a union.

Job Classes

For unionized employees, job descriptions are available and these include details on qualifications, duties and responsibilities. As is the case for many jobs performed by women in the health care field, however, these descriptions do not necessarily capture all aspects of the skills, responsibilities, effort and working conditions involved in providing care. The job description of nurses in the home care program, for example, list ten duties and responsibilities which indicate that these workers have to provide nursing care as directed by both the physician and the coordinator of the Home Care Program and to interpret the Program for both patients and professionals. The description fails to capture the wide range of skills required to treat patients who may have any kind of chronic or acute condition, especially during a period when hospitals are reducing the length of patient stays and sending patients home at an earlier stage in their recovery. One home care nurse we interviewed described how she began her day with a visit to a child who needed antibiotics administered by intravenous; moved on to a patient with terminal cancer who had not yet been informed of the prognosis, then to two diabetics with very different related problems, continued on to a patient with congestive heart failure who required adjustments to medication, and to a patient with Altzheimers' who needs help reorganizing her living arrangements and ended with a return to the patient requiring antibiotics, a visit that involved training another nurse in the use of new equipment. The description does not indicate that "it's kind of scary doing the treatments at home alone" or that "going into someone's house is different than being in charge in the hospital; you're on your own". Nor does it include the constant training necessary to provide such a variety of treatments and to keep up with new techniques; or the fact that a great deal of the treatment in terms of such areas as medication is left to the nurse "because she's better able to judge than the doctor because she sees the patient regularly ".

The salary scales for the recognized jobs are clearly established and readily available, making at least these factors involved in determining jobs easy to establish. Jobs are publicly advertised and benefits are set out in the collective agreements. Job classes are fairly easy to identify from salary scales and job descriptions.

For the employees of the VON and the Red Cross, job descriptions and pay scales are more difficult to acquire because they are not set out in collective agreements. According to the Red Cross, in this unit a homemaker providing service for the Health Unit "must participate in a basic training course where they learn about nutrition, child and adult care, human behaviour, hygiene, and personal care, treatment of common illnesses, first aid, transfer techniques, budgeting and household management. The in service training is continued throughout their careers: A homemakers' duties include general housekeeping, laundry, planning and preparation of meals, shopping and banking, care of children, personal care such as sponge bath, bed pan or hair care, and medications or dressings if specific instructions are given by a doctor or nurse as well as specialized care for the physically or mentally handicapped and support for those facing stressful situations in their households". But even these descriptions do not indicate, for example, that homemakers "travel by car, bus, walking. In the northern area with terrible weather conditions all homemakers will still venture out to their clients because of the need. In some situations, the homemaker may be the only contact that client may encounter".

Nurses of the VON, like nurses in most areas, tend to be simply described as registered nurses who provide nursing care in the home. Clerical workers in this office do not seem to have job descriptions.

In spite of the limited nature of many job descriptions, male and female job classes will not in general be difficult to establish.

The VON in this district office employs 21 nurses, eight of whom are employed full-time. One of these nurses is male. The two clerical workers are both female.

The Red Cross hires 219 homemakers. All these employees are women. Although they are all hired as full-time workers, they are not guaranteed full-time work. All 15 members of the office staff are women. In this area, there is one male executive director but there is also a female who holds a similar position.

The Public Health Unit employs the equivalent of 116.4 full-time workers. The data are not available on total employees but almost all these employees work full-time.

Only eight of these employees are male. One is the senior inspector, and one is the audiologist. The audiologist's job has traditionally been held by a male but he is leaving and may or may not be replaced by a male. Six of the eight, or 75%, of the staff inspectors are male and, although the proportion of males and females employed overtime has varied, staff inspector will likely qualify as a male job class. Two senior administrators are male. All other jobs are female-dominated.

Wage Rates

Salary scales and schedules suggest that job classes match job classifications and that major differences exist across job classes. Among the employees working directly for the public health unit, two female job classes have higher annual salaries than the male dominated senior inspector category and three other female job classes have wage rates higher than the male dominated staff inspector category. Nine female job classes have salary scales below those of the inspectors. The nurses' salaries have not been included in the above because there are variations over time in terms of whether nurses are paid more than inspectors.

The starting wage for Red Cross homemakers is $4.79 an hour and they are not paid for travel between cases. They are only paid for face to face contact they have with clients. According to the Homemaker Supervisor, "in many cases this amounts to pay for four hours out of what is a six-eight hour work day". Low wages, according to the Red Cross, largely account for the fact that the homemaker "turnover rate during the first 9 months of 1987 was 61%" (1988:3). The homemakers are "grossly underpaid, without benefits or job security" as one member explained.

Comparators

The only easily established male job class in this Public Health unit is that of staff inspector. This job could provide a comparator within the CUPE bargaining unit. The senior inspector may also, on the basis of historical incumbency and gender stereotype, constitute a male job class within the CUPE bargaining unit. There is no male comparator within the ONA bargaining unit and thus the only comparator available outside the bargaining unit but within the establishment would be the inspectors.

If nurse are compared to staff inspectors, there is likely to be little change in salary. Though it may well be argued that nursing requires more skill, effort and responsibility than inspection does and that the working conditions are more onorous, there are only minor, and fluctuating, differences in their salary scales.

It is not immediately clear if any of the female dominated jobs within the bargaining unit that includes the inspectors will be deemed comparable in terms of skill, effort, responsibility and working conditions to those of the inspector. According to a senior executive, the only job class that is paid less, but that may be evaluated in a new gender free system as of comparable worth, is nursing.

If the senior inspector constitutes a male job class, then the chiropodists, the social workers, the dental educators, and the hygienists, may all argue that, in terms of skill, effort, responsibility and working conditions, their job is worth at least as much. Comparing these jobs to those of staff inspectors alone would have no impact because they are already paid more than staff inspectors.

For the women working in the Red Cross and the VON, these are no comparators within their respective establishments.

Pay Equity

The 43 Ontario health units, through their Association, have hired a consulting firm to develop a pilot job evaluation for pay equity. Jobs and classifications are similar throughout the province and this generic plan will be adopted to local conditions. Each unit will negotiate individually with their local unions and pay equity will be negotiated separately from collective bargaining issues.

The Pay Equity Act is likely to have a very limited impact. It may raise slightly the wages of the 28 public health nurses that work in the unit. More substantial gains would be made by the 8 women who work as hygienists, chiropodists, social workers and dental educators if they could compare to the senior inspector. This still leaves the majority of female employees--and most of these the lowest paid--without comparators and therefore without wage gains.

In the case of the 20 women who work as VON nurses and the two who do office work for the VON, the Act will not apply because they have no comparators in their establishment.

For the 219 women who provide homecare through the Red Cross, there will be no change under the Pay Equity Act, even though it is clear that these women perform onorous, skilled work under often unpleasant conditions at jobs that involve considerable responsibility for peoples' health and recovery. In many cases, they do work that was formerly carried out by much more highly paid staff in hospitals.

Here is a classic example of a female dominated occupation. A wide range of skills are required but these skills remain largely invisible both because they are done in the home and because it is assumed that any woman can make beds, clean bottoms, change clothes, wash faces, calm, and feed patients; toilet large and small individuals. Many must be bilingual. The responsibility for administering such care to frail, impatient and sometimes hostile individuals is also assumed to come naturally to all women and it too remains invisible. The strength required to lift heavy patients, the effort required to encourage them to eat, the conditions involved in changing adult diapers go unrecognized. While the Red Cross does search for women who live in households where there is a second income, many of the women who do this work are their own sole support and a number are single parents without additional income. Such women live below the poverty line, even when they are allocated full-time work. These jobs--among the lowest paid of all jobs and the majority of jobs in the Public Health Unit--will not be altered by the Pay Equity Act.

The amount the Red Cross, a non-profit organization, pays to its employees is largely determined by what the Province pays the Red Cross. The person we interviewed at the Red Cross argued that as the province seeks to save money and alter care practices by sending patients home, the jobs in this class will expand. Under the Pay Equity Act, the pay will not.

Profile of a Medical Clinic

This large clinic is owned by the physicians who work there. In addition to these physicians-owners, 23 specialists visit the clinic for half a day a week. The clinic is open week days from 9 a.m. to 8 p.m. and some Saturdays.

Establishment

The clinic would fall under the definition of establishment in the Pay Equity legislation. It is not part of a chain or region group but rather is an independent operation.

Employer

The employer would be the doctors who manage the clinic. They are responsible for establishing the number and pay of all jobs.

Bargaining Units

None of the 85 employees belong to a union. Asked about unions, one nurse replied: "We have tried being reasonable, have tried asking for more money but we just aren't listened to. For the first time, we are seriously considering a union. We have one of the nurses checking with ONA". An x-ray technician said salaries and benefits were inadequate but "There's not much you can do about it unless you get a union in. I don't want to get into a union. I think it would make the atmosphere even worse. Besides, we don't have enough employees to start one".

Pay Equity plans, therefore, are the perogative of the doctors.

Job Classes

One of the 85 employees is male and he is one of 3 pharmacy clerks. With two-thirds of the clerks female, this is clearly not a male job class. Indeed, it may qualify as a female job class on the basis of historical incumbency. The non-medical staff consists of administrators, clerical workers, receptionists, medical records/chart room clerks, laundry workers and a part-time computer operator. There are also nurses (all but one of whom works part-time), technicians, physiotherapists, pharmacists, as well as pharmacy clerks and assistants, and dieticians. Written job descriptions are not available, and according to one employee, there are no written job qualifications.

Wage Rates

Wage scales were not available. All full-time employees receive 50% of family coverage and 100% of single coverage for OHIP. There is also a life insurance and medical plan for full-time employees. The latter does not include prescription drugs but employees can have their prescriptions filled at cost in the pharmacy. Part-time employees, a large proportion of the staff, have no benefits. "They will not pay for the first day you are off sick, but will pay on the second day. If you are sick for 3 days, a doctor's note is required. It is really difficult for a single parent to lose pay for a whole day".

A records clerk with 6 years experience makes "about $12,000 a year" and "some with 10 years experience get $16,000". She "could be a receptionist and make $50 more every two weeks". Starting salary for nurses is $12 an hour, $3.85 less than for a hospital nurse working at ONA rates. One nurse explained that "the gap in pay is increasing all the time between clinic and hospital. Many of us are now having great difficulty accepting the difference". Another nurse maintained that nurses came to the clinic "because we were so tired and fed up with working shift. Most of us have worked so much of it, for so long, that we just want to avoid it...Personally, I found hospital jobs too frustrating...having 14 patients and not being able, not have time, to give the care needed. It was too much". The pay difference is so considerable, however, that nurses who want full-time work would return to the hospital setting.

Full-time x-ray technicians are paid $13.50 an hour; part-time $14.00. One technician attributes the better pay of technicians to the fact that no one answered their advertisement for the job. Until then, technicians made $11.80 per hour. "I think we get better treatment because radiology is a money-making area for them. The nurses, on the other hand, are not such a money making area. They get lousy pay". One clerk summed up the situation by saying "we are understaffed, overworked and underpaid". There is little opportunity to improve wages through promotions because "there aren't any. There's nowhere to go".

Comparator

There are no male job classes, and therefore no comparators, unless the doctor owners are included.

These health care workers, already paid less than their counterparts in the hospital, will not see their salaries increased under Pay Equity. Indeed, the gap between them and hospital employees may increase if women working in hospitals find comparable male job classes that are more highly paid.

Yet these women do work that is very much like hospital work in terms of the level of skill, effort, and responsibility required, even if the kinds of skills and conditions of work are different. As one nurse explained:

"You need a different kind of nursing knowledge. Most of the things done here are not done on regular floors in the hospital. For example, allergy shots are given, children are immunized, and there is frequent liaison with various community services. We work with different doctors, and do all the phone work, booking tests outside of the clinic, calling for results. We also assist with minor operations and diagnostic procedures...sterile procedure stuff...prep patients...order needed supplies...We also check the examining rooms and offices, change the linen when necessary, ready the equipment for the procedure. There are a number of patients who see only the nurse...those who come in for regular allergy shots, or other types of medication...we check daily for these lists. Doctors also refer some of their patients back to us if they need blood taken, sutures removed or dressings changed. At the same time, we have to constantly run around making sure all the rooms are clean and ready. There is a steady flow of patients always and if we have any spare time at all, we check to make sure meds and sterilized equipment are not outdated, and that shelves are well stocked. There is a great deal of patient teaching, such as teaching how to administer self-injections, about cholesterol and other diet issues...There is also frequent pressure from doctors agitating to use the same room...this depends on which doctors are in...different doctors use the same room...Some doctors see 60 patients daily, which would be 300 or 400 per floor".

An x-ray technician felt that "it is really sad that there is such a great difference between clinics and the hospitals. We have just as much stress here as they have in hospitals; even though people are less ill." Although the records clerk we interviewed was a long term employee;

"everyone else just stays for a while and leaves because of the money and the stress...The pressure starts by 9:30 and just keeps going".

These women too face health hazards and must put a great deal of effort into their work. "People fall off stools a lot" when they are searching for records on high shelves. As well, they "are getting varicose veins from being on our feet all day" and "our backs hurt from bending and carrying charts". Although patients are not as ill as they are in the hospital, one nurse described how "I often get a tired back, legs and feet, and there is the constant stress of something happening all the time". The x-ray technician felt that their equipment was safe and that they did have a good relationship with doctors but she also felt "a responsibility for reading the films if the radiologist isn't around. I would feel so awful if a patient went home and something was missed."

Pay Equity

There are, as yet, no plans for Pay Equity. Because there are no male job classes, the development of the plan should be simple. None of the 84 women who work here will qualify for raises under the Act.

Profile of a Residential Psychiatric Facility

These two high support houses for ex-psychiatric patients are directed by the same manager. The 10 residents in one house and 8 in the other may attend school, work for pay or remain in the house full-time. The houses are continually staffed and are funded primarily by the Ministry of Health, although some other fundraising is done.

Establishment

Because the same manager is responsible for two houses, both would probably be considered part of the same establishment. Whether or not it would be possible to link these houses with others for the purposes of Pay Equity is unclear.

Employer

Although funded by the Ministry of Health, those who work in these houses are not government employees. The manager is responsible for hiring, firing and disciplining employees and therefore would probably be considered the employer of workers in both houses.

Bargaining Units

A total of 20 people work in both houses but only the part-time secretary is unionized. This may mean two pay equity plans, one for the secretary and one for the non-unionized employees. Six of these workers are volunteers and therefore do not fall under the Pay Equity legislation. Two are students from a local community college and they too are unpaid.

Job Classes

Only one of the 8 community health counsellors is a male and therefore this group would constitute a female job class. Both supervisors are female, leaving little doubt that this too is a female job class. The one secretary is female, a female job class by herself. The other male working in these two houses is the manager.

Wage Rates

The salary range for the manager is $2,896 to $3,488 per month; for the supervisors $2,353 to $2,787 and for the Community Health Counsellors,

$1,865 to $2,085 after 3 years. The starting hourly rate for the secretary is $9.93 and can go up to $10.93 after 3 years.

Comparators

There is only one male job class, that of manager. Given that his job description says he is responsible for program design, for personnel, for budgets and other administrative work as well as for some clinical tasks, it seems unlikely that the three female job classes of supervisors, community health counsellor and secretary will be able to establish the manager as a comparator.

Community health counsellors do, according to their job descriptions, participate in the planning and evaluation of programs, in the implementation of policy and in selecting, training and evaluation of both students and volunteers. They are also required to compile and maintain statistical and budgetary data and to be members of committees. Their clinical work includes the admission, review and discharging of clients; the provision of support and guidance as well as the teaching of life skills. Residents must be self-medicating but counsellors monitor them to make sure they take their drugs. Unlike the manager, they do shift work, although he is on call 24 hours a day.

Each Counsellor is responsible for a specific program and is assigned clients who are their primary responsibility. At night, these Counsellors are usually in charge. "You're still responsible. There's 10 people; they come in at all hours of the night". "We are working not just with individuals but with a group at the same time in their living situation, which is different from coming into my office for an hour at the hospital and that's it."

The female supervisors "make sure the counsellors do their job". They too are on call. Their jobs require "counselling skills, listening skills, strong communication skills, co-operation and people skills". They are also involved in hiring and in preparing cost estimates for budgets. As well they attend a variety of meetings and occasionally consult with clients' families. Both supervisors and counsellors deal with schizophrenics, those who are manic depressives or who have personality disorders.

Pay Equity

Under the Pay Equity legislation, it seems unlikely that any pay adjustments will be proposed. There is only one male job class, that of manager. It will be difficult for the women, who constitute 75 percent of those working in these houses, to establish a comparison with this job.

Profile of a Detoxification Centre

Funded by government money, this detoxification centre serves as a model for other centres in Ontario. The residents are all male. Although established to deal with alcohol addiction, more and more of the men who come to the centre have multiple dependencies; that is, in addition to alcohol, residents are also addicted to other drugs such as cocaine or heroin. According to the manager, detoxification centres save the health system a tremendous amount of money because the residents can be serviced at considerably less expense than in a hospital.

Establishment

The detoxification centre is a separate unit with its own budget. It does, however, maintain very close liaisons with a hospital and some services are shared. Whether this sharing is sufficient to constitute the centre as part of the hospital is unclear.

Employer

Employees are hired and supervised by the centre, suggesting that the employer is the centre. No services are contracted out. Both residents and attendant do cooking and cleaning.

Bargaining Units

With the exception of the manager and the supervisor, all employees belong to SEIU. Because they are considered an essential service, the Hospital Labour Dispute Arbitration Act applies. There is no central bargaining so pay equity would be negotiated with the centre.

Job Classes

Only 9 people work in this centre. There are two male managers and 7 detoxification attendants, three of whom are male. There is then, no easily established male or female job class outside the managerial group. Neither historical precedent or stereotyping would apply, given that both women and men have been involved in this work.

Wage Rates

The 1987 Collective Agreement set an entry rate of $11.03 per hour. This increases to $11.23 per hour after one year and to $11.34 an hour after two years. Wages and benefits are the same for women and men.

Comparator

There are no comparators because there are no male job classes outside the managerial group. The job descriptions of the manager and the supervisor suggest that these jobs will not be judged comparable to those of the detox attendants.

Detoxification attendants do both housekeeping and clinical work. Housekeeping duties include cooking, laundry, dishes, washing floors and planning meals. Attendants also encourage residents to help with the cleaning.

According to the job description, attendants must have completed high school, a C.P.R. and St. John's Ambulance First Aid course for Orientation to Detoxification Services program and have training in the management of withdrawal from drugs. In addition, attendants are expected to be skilled in communication, sympathetic and able to deal with "extreme and potentially violent behaviour". As one attendant explained, residents' "behaviour is bizarre and erratic and sometimes violent". Residents are admitted and discharged by attendants. Attendants also monitor residents' frequent seizures, in order to "make sure that they don't hurt themselves physically, and watch them to make sure they keep breathing and don't die, right there". At the same time, attendants must constantly reassure other residents because seizures can have a domino effect and create a medical crisis in the centre.

Pay Equity

Pay Equity legislation will probably have no impact on this centre, given that there are no easily established male or female job classes. If all detoxification centres are treated as one establishment or if this one was included in the hospital, then the picture could change.

Profile of a Residential Treatment Centre for Alcoholism

This publically funded treatment centre operates three residences; two for men and one for women. They offer a 28 day treatment program for alcoholics. The financing comes from provincial health care programs. The cost of treatment is low compared to other similar centres, homecare or hospital treatment. Their success rate is also relatively high. Of the 60 people employed in these houses, 19, or 32%, are female and 22 work part-time.

Establishment

Because all three houses are connected for administrative purposes, they would probably be considered one establishment. The combination could be important because all but two of the people working in the men's houses are male while all but one of those working in the women's house are female.

Employer

Although paid indirectly by the Province, employees are hired and supervised by the managers at the centre.

Bargaining Units

None of the staff belong to a union. There would then be one Pay Equity Plan.

Job Classes

In all 3 houses, the maintenance work is done by men but this is the only easily established male job class. If all the counsellors--both full and part-time in both houses--are taken together, then this job would be more than 70 percent male. All the counsellors in the women's house are female however and all those in the men's houses are male. One of the 3 managers and one of the 3 assistant managers is female. Two of the eight cooks are also women. Only if the houses are treated separately would female job classes exist.

Wage Rates

There are 3 pay levels in maintenance work, ranging from $14,000 a year to $17,000 a year. All full-time cooks receive higher wages than maintenance workers, and the wages of counsellor fall between those of managers and cooks. In other words, the clearly established male dominated class is also the lowest paid.

No information was available on benefits. All counsellors and cooks work shifts.

Comparators

Given that the lowest paid job class is male dominated and that there are no easily established female job classes if all 3 houses are considered one establishment, there are no comparators. It is interesting to note, however, that this was the only establishment we examined that was male dominated, that had the lowest paid job class dominated by men and that had such low wages for maintenance.

Pay Equity Plans

A consulting firm has analyzed wage rates and developed job descriptions for the Ministry of Health. This report will probably be the basis for a Pay Equity Plan. It seems unlikely that any adjustments will be judged necessary.

Profile of a City Ambulance Service

Owned by a municipality, this ambulance service employs 937 people, 134 of whom are women. It answers about 390,000 calls a year, 60 percent of which are transfers between hospitals and homes.

Establishment

Although there are 40 ambulance stations which belong to this service, they are all within the same geographical region and therefore would constitute one establishment.

Employer

All are employed by the city although some work for another employer as well.

Bargaining Units

All non-management employees belong to one of two unions. The drivers and paramedics belong to one local and the dispatchers and clerical workers to another. Strikes and lockouts are not permitted. As is the case with many unions, jobs must first be advertised to union members before a public advertisement appears.

Job Classes

Women account for just over 14 percent of all employees but 84 percent of the clerical workers are female. Men are the majority of the dispatchers, although women make up 42 percent of this group. Over 90 percent of the drivers/attendants and managers are male. There are no women paramedics and no women do other jobs in the ambulance services. Within the local that includes the dispatchers and the only female job class, there is not a male comparator. However, both paramedics and drivers fall into male job classes in the other bargaining unit within the establishment.

Wage Rates

Of the four major job categories in this service, clerical workers receive the lowest entry rate. Dispatchers, however, start at a rate higher than that of drivers/attendants, even though women constitute a higher proportion of the former group. Paramedics have the highest entry and ceiling rate, with a starting wage of $16.65 an hour. Their entry rate is higher than that of a registered nurse working in a hospital.

Many of the workers are classified as full-time temporary workers. After a years employment, they are eligible for benefits. While these benefits include vacations and pensions, all of the workers in this ambulance service are only permitted the unpaid maternity leave required by law.

According to their brochure, drivers/attendants have several career possibilities. They can become district supervisors or they can be trained in special services or take the additional 1900 hours instructional training which makes them eligible, after 3 years service as a driver attendant, to become paramedics. No career paths are mentioned for the mainly female clerical workers and most of the clerical workers employed in this ambulance service are classified into the lowest clerical level.

Comparators

There are no male comparators within the bargaining unit for the female dominated clerical workers but there are two male job classes within the other bargaining unit in the same establishment. Given current job descriptions, it is unlikely that these female clerks will be judged to have skills, and responsibilities similar to those of the driver/attendants or the paramedics and the more similar dispatcher job is only 58% male. It could perhaps be argued that this has traditionally been a male job, however.

According to the job descriptions, driver/attendants must have a community college course in ambulance and emergency care or the equivalent, a Class F driving permit and knowledge of both traffic regulations and the location of as well as the services provided in hospitals. Two driver/attendants are assigned to each vehicle and they are "responsible for the vehicle, the equipment and the patient. The day shift begins with a vehicle and equipment check, which takes up to a half hour. The drivers are responsible for the vehicle and no one else is allowed to drive the vehicle, except in extreme circumstances where either police or fire fighting personnel may drive if both attendants are busy...Once we arrive at the scene, we are in total control of patient care. Even if police or the fire department have arrived, we take over". Although about 60 percent of the calls involve routine transfers of patients between hospital and home, the other 40 percent involve emergency situations. Driver/attendants are exposed to communicable diseases, abusive or violent behaviour and, especially in the busier stations located in the core of the city, high levels of stress, given that they may answer as many as 18 calls a day and these may involve a wide variety of difficult conditions. "They do C.P.R., splinting, patient assessment; they also do early defibrillation".

The paramedics have all the skills listed under ambulance driver/attendant plus several more. "They are able to carry out medical procedures such as incubation and tracheostomies."

Like the driver/attendants, the clerical workers must have a secondary school certificate or the equivalent. They are required as well to have 2 years office experience, have computer and bookkeeping skills, typing speed and skill in operating a wide range of office equipment, knowledge of data processing and the "ability to maintain co-operative working relationships with other members of the staff and the general public". In addition to office correspondence, receptionist duties and "routine accounting", they are "responsible for maintaining a complex and efficient filing and retrieval system involving various types of information".

Dispatchers, too, must have the equivalent of a secondary school certificate and a First Aid Certificate. They must be experienced in switchboard operation, be able to operate a two-way radio and a keyboard. They work on rotating shifts, scheduling and dispatching ambulances. Their range of skills is less than those required of the clerks but they do hear from people who are often under greater stress than those who usually contact the office.

Pay Equity Plans

This ambulance service is monitoring both the race and sex composition of their workforce. The city is developing proposals for Pay Equity.

The one female job class could benefit from Pay Equity if dispatchers were judged a male job class on the basis of historical incumbency and if their work was judged comparable to that of clerks. It seems unlikely that current job descriptions will allow the two male job classes of driver/attendant and paramedics to be of comparable work to the clerical job.

Profile of a Private Laboratory/Specimen Collection Center

This private laboratory employs approximately 565 people in a variety of locations within the same geographical area. Eighty-six percent of the employees are women and 90 percent of them work full-time. This laboratory does routine testing and analysis of specimens from private and public institutions. It also acts as a reference laboratory.

Establishment

Although there are a variety of satellite stations throughout the area, all testing is done at the main office. This would suggest that all these stations are part of the same establishment.

Employer

The employer is the group that owns this private company. They are responsible for hiring, firing, supervision and the establishment of salaries.

Bargaining Units

No employees belong to a union. Therefore, there are no bargaining units and one employer-devised plan will be sufficient.

Job Classes

According to the person we interviewed from the Human Resource Department, there are no male job classes in this establishment. Most of the people who work as laboratory assistants, technologists, data processors, supervisors and department managers are women.

Wage Rates

Wage rates in this laboratory are lower than hospital rates but similar to other private laboratories. Technologists 1 earn between $2,300 and $2,824 per month. Technologists II begin at $2,300 a month and could move up to $2,824 per month. The majority of technologists are in this category. The third technologist category involves supervisory work and has a maximum salary of $3,514 per month. Lab assistants, who account for a smaller proportion of the workforce, earn between $1,329 and $2,824 per month in their three levels.. No salary data were available for the large number of women who do data processing and other clerical tasks.

Employees are eligible for a drug prescription plan, they contribute to a dental plan and may join a group insurance scheme. After a year, employees are eligible for 3 weeks vacation.

There are no automatic annual percentage increases in pay. The company pays merit pay. In the first part of each year, supervisors meet to evaluate individuals within their departments. Each employee also does a self-evaluation. Both these evaluations provide the basis for the Human

Resources Department's decisions on pay increases. Last year, the increase averaged 5 percent.

The company will reimburse technologists for the cost of courses that upgrade their skills. Both technologists and assistants can move through 3 levels within their categories but they cannot move from one to the other without retraining outside the lab.

Comparators

There are, according to the employer, no male job classes.

Lab assistants and technologists do shift work. Many of the lab assistants work in the evening shift, handling specimens, sorting and labelling them. They are required to have at least grade ten and to have Career Canada certification.

Technologists usually have at least two years training in a community college and no experience is required to begin at the lowest level. The technologist 1 we interviewed explained that she specialized in microbiology, rather than haematology or blood banks because: "To me, its too life deciding, any little mistake, like blood bank, is too particular- you could kill someone so fast. I didn't want to have that pressure". She estimates that they handle more work than is typical for a hospital laboratory. "Talking to people who have come from a hospital, they find it hard to adapt to the numbers". A technologist III, however, felt that "many people who work in the hospital couldn't cope with the pressure there."

Another technologist mentioned the hazardous environment experienced by all employees, although part of the training for technologists and assistants is the techniques involved in minimizing risk.

Technologists in all levels are responsible for visual matching and computer matching, for chemical analysis, the detection of suspicious results and the paper work related to this analysis. While machines do more and more of the actual analysis, employees must be able to do the analysis without this sophisticated equipment when it breaks down. "It is our duty to perform all chemical analysis within rigorous standards...In the event of error, the actions are reversible only if a senior technologist detects it and requests a repeat. However, our position requires us to perform at minimal error rates". Many technologists rotate through different stations in this very large laboratory with its row after row of tables. The common pattern is a 2 week rotation through each.

Pay Equity Plans

The company has hired a consulting firm to evaluate all jobs. If those in the Human Resources Department are correct, however, there are no male job classes. Therefore, there will be no requirement for adjustments under Pay Equity. The nearly 500 women who work in this lab will not be eligible for pay increases under the Act.

Profile of a Registry for Health Care Workers

This incorporated company provides temporary health care workers for private individuals and institutions, as well as for public facilities. Because the volume of work available is related to demand, the exact number of employees paid by this service varies from week to week. The number of shifts filled each week varies from 300 to 350 and the kinds of personnel employed also varies, depending on both the kind of service required and the hours of employment requested.

Establishment

This company has offices across Canada but the establishment will probably be defined in terms of the area serviced, in this case a major city.

Employer

The employer is this incorporated company. Although the people they pay actually work in other institutions and are supervised by these institutions, the employees are paid by the company.

Bargaining Unit

Employees do not belong to unions.

Job Classes

The company employs registered nurses of various kinds, RNAs, Health Care Aides and Homemakers. While the person in charge of this office reported that they do not keep records of employees' sex, unless this is a very unusual group it can be assumed that most of the people who take employment through the registry are women. The total number of people registered with the service also was not available, but given the volume of shifts filled, it must include well over 400 people.

Wage Rates

Workers are paid according to the assignment, their experience and the area of specialization. Rates for a general duty nurse are $18 an hour or $135 per shift when they work in institutions such as hospitals and $16.75 and hour or $134 a shift if they provide home care. RNAs rates are $12 an hour or $90 a shift in institutions compared to $10.50 per hour or $110 a shift in a home. Health Care Aides also have higher rates for an institution; $7.28 an hour or $54.60 a shift compared to $6.55 an hour or $52.40 a shift. Homemakers rates are lower than those of Home Care Aides. These aides must have their certificate in home care.

Employees have a benefit package which includes "a health and dental plan, life and short term disability insurance". It does not seem to include sick pay or vacation pay.

Comparator

There are no comparators, given that all the people employed by the company work in female dominated jobs.

Women in particular are attracted to these registries because they have more control over how much work they do each week and each year. Many are women who have "burned out" in full-time health care work. While moving from job to job does increase variety, it also increases tension because each job has different demands, different patients, different equipment and different personnel. The satisfaction that comes from getting to see a patient through an illness or from working with a team that has developed a cooperative relationship is difficult to find in this kind of employment.

Pay Equity Plans

As the person we interviewed explained, it would be difficult to develop a plan because there are no male job classes and because all people working in each of the 4 job classes they deal with are paid the same wage, regardless of sex.

Profile of a Laundry Operated Exclusively for a Hospital

This laundry is owned and operated by 20 member hospitals. It employs 300 people; 250 work full-time while 50 are employed part-time. According to the person we interviewed, approximately 20, or less than 7 percent, of these workers are men.

Establishment

Although this laundry is a non-profit service operated by a group of hospitals, it will probably constitute a separate establishment.

Employer

Similarly, the employer will probably be the laundry itself rather than the hospitals that own the service. The delivery trucks and drivers work for a separate company.

Bargaining Units

All non-management employees belong to the Textile Processors, Service Trades, Health Care, Professional, Technical Employees International Union.

Job Classes

There are, according to the person we interviewed, only two job classes in the laundry. One involves ironing, folding and pack-making in what is called the clean side. This work is done almost exclusively by women. Almost all these women are Italian in origin. Many are married with grown children.

The other job class involves working in what is called the soiled side of the plant where laundry is loaded and sorted onto conveyor belts. Most of the men work in this job but they do not constitute 60 percent of the employees.

While there are two different kinds of work, each with a separate pay rate and different duties, there are not 2 easily established job classes.

Students are hired during the summer to work in both areas but they are paid a lower rate.

Wage Rates

The starting hourly rate for those working on the "clean" side is $8.66 an hour; for those on the "soiled" side, it is $9.86 an hour.

Wages and benefits are set out in the contract and are similar for all employees.

Comparator

There appears to be no male comparator. While men who work loading trucks are paid more than the women who iron and fold, many women are also paid at this higher rate.

Pay Equity Plans

A consulting firm is reviewing the situation but it is anticipated that no adjustments will be required under Pay Equity because there is no male job class and because little functional distinction is made between jobs.

Conclusion

It is difficult to accurately predict the impact of Pay Equity on many of these institutions because a great deal will depend on how the establishment, the employer, the job classes and job evaluations are defined. In turn, these definitions in many cases will depend on negotiations between employers and unions.

However, it is very unlikely that the many women who work in clinics, laundries, residential facilities and laboratories will find comparable male job classes and these women are among the lowest paid in the sector.

The women employed in large hospitals and nursing homes are in the best position to find male comparators. If, however, one pilot study based on a consulting firm's job evaluation scheme is any indication, the women most likely to benefit are those near the top of the hierarchy, those with the skills most easily measured and most like those associated with traditionally male jobs. The many women in dietary, housekeeping and aides jobs may find their work evaluated as lower in terms of worth than the male jobs in areas such as maintenance, if traditional criteria apply.

In smaller hospitals, there are very few male job classes. Whether or not women in the lowest paid job categories will benefit from Pay Equity will depend on how their jobs are evaluated in relation to maintenance work in particular. The women in higher paid categories are unlikely to find comparators in these small hospitals.

Women who work for nursing registries, or other independent agencies such as the V.O.N. or the Red Cross, are unlikely to find comparators in their establishments.

In sum, a large number of women in the health sector are unlikely to find comparators and thus to see their pay raised as a result of Pay Equity.

Chapter 5

Conclusions, Future Trends, Options

Health care is women's work. As a result, few of the one in ten employed women in Ontario who hold jobs in this field will benefit from the Pay Equity Act.

Many female health care workers will not find male job classes in their establishments. Most will not find male job classes of equivalent value. This is a consequence of:

1. The extreme sex segregation in terms of both jobs and establishments. Almost all of those providing nursing care and doing clerical work are women and so are the majority of those in technologies, housekeeping and dietary services. Many work in all female establishments such as the VON or in small clinics with only a male doctor to direct them.
2. The concentration of men at the top and near the bottom of the health care hierarchy. The male doctors and administrators will not likely provide comparators because most of the doctors are classified as self-employed and the administrators are usually judged to have special managerial skills that are worth more than caring skills. While the maintenance workers and those in trade say provide male comparators in many establishments, they will not likely serve as comparators for the majority of women who work as nurses, therapists and technologists.
3. The structure of job evaluation schemes. While the Pay

> Equity Act calls for gender-free job evaluations, most are based on the assumption that skills, effort, responsibilities and working conditions can be measured in objective, finite terms and that current employment practices are based on the value of skills, effort, responsibilities and working conditions-even if those of women have been inaccurately counted. As a result, many schemes judged to be value free merely reinforce the higher value placed on what men do. Furthermore, these schemes often reinforce the current hierarchy, given that men are usually found classified in the supervisory or top category of the class in which they work.

Furthermore, the implementation of Pay Equity may serve to increase differences among women, while leaving the majority of women without higher wages or benefits. This may result from the presence of equivalent male comparators in large hospitals and their absence in many smaller establishments, and from the development of more than one Plan in each establishment.

Four additional points should be made about women's work. First, most of the women who work in health care have very limited opportunities for advancement. Few can improve their wages or benefits significantly by working harder, by taking extra courses, by learning how to operate new equipment or by excelling in their job.

Second, very few women are eligible for merit pay. Merit compensation is explicitly excluded from the legislation as long as it is not based on gender-biased evaluation schemes. Yet merit pay in health care establishments seems to be primarily found in male dominated administrative and management jobs. Thus, exempting merit pay mainly means not counting part of male earnings and counting all of female earnings.

Third, skill shortages in the areas where women work do not seem to translate into higher wages. Nurses provide an obvious example. Wages have not risen in response to a scarcity of these workers. Yet the exemption related to scarcity may be used to justify higher wages paid to the men doing maintenance work in Northern Ontario and the male psychiatric attendants in Toronto. Shortages themselves are not gender free categories.

Fourth, the exemption related to training also applies in different ways to women and men. RNs, RNAs, HCAs, therapists and dieticians all do lengthy internships that are unpaid. At the same time, men do apprenticeship programs that are paid and Provincial regulations ensure that this is the case. In both cases, those learning the job are providing services while they are acquiring additional skills but the predominately male group is paid while the predominately female group is not.

Finally, there are several specific points that were raised by employers as well as by the employees.

1. Problems defining establishment, employer, job class, wage rates and comparators, even with the help of the guidelines from the Commission.
2. Absence of guidelines on the information required from employers in order to determine Pay Equity.
3. Failure of the Provincial Government to provide funds for Pay Equity. Many employers and employer organizations said that they were in sympathy with the legislation but additional funds are required in order to compensate employees under Pay Equity Plans.

Paying for Pay Equity may, under these conditions, mean reducing Services and facilities for women served by the health care system.

4. A one-time adjustment. This means that new employers may introduce wage gaps and that wage gaps may reappear. Employers, as we were told, are assumed guilty until a certain date and then they are assumed innocent.

Under the Pay Equity Act, the systemic discrimination identified in the Green Paper will not be dealt with systematically.

Future Trends:

The following future trends were noted in the literature, and by advocacy groups, as ones which will have an impact on pay differences between women and men:

1. Increasing use of health care workers employed by registries or other agencies. These services usually charge higher rates than those paid to regular employees but the workers are often paid less and few receive benefits. The growth of these services reflect women's dissatisfaction with current conditions in the health care system.
2. Increasing use of homemakers and Health Care Aides. The move to send patients home sooner and to save money by providing homecare has raised the demand for women to provide this care. At the same time, the shortage of both RNs and RNAs has increased the demand for Health Care Aides in the rapidly expanding long-term

care establishments. Health Care Aides and Homemakers are among the lowest paid female workers and few of them will find male comparators under current legislation.

3. Continuing growth in certification and higher levels of formal education. The nurses and the many other female health care workers who are expanding their education and skills will be demanding more power and recognition as well as higher wages. They will also become increasingly frustrated with limited promotion possibilities, especially as more women remain continuously in the labour force.
4. Growth in the part-time labour force. Employers' efforts to reduce costs and women's attempts to deal with their conditions of work have contributed to the enormous growth in the part-time workforce. According to The Canadian Nurse (Freise and Stefura, 1983:20) the "percentage of part-time nurses on staff can be as high as 83 per cent". Most part-time workers receive fewer benefits than full-time employees and many are paid lower hourly rates.
5. Contracting out services. As more health care services are privatized, public health care institutions will have fewer employees in their establishments. Employees, especially female employees, tend to be paid less by private contractors and fewer of them belong to unions than is the case in the public sector.
6. Free trade may mean that current government financing of health care will be challenged. The reduction in state funding which could result would reduce women's opportunities to improve their

wages and conditions. A report to Health and Welfare Canada (Associated Health Planners, 1985:9) noted that "Private management and 'for-profit' ownerships are hallmarks of the United States System. Yet Americans are grappling as intensively as Canadians with their hospital and health care costs, and they face an equally urgent need to get them under control". New management could mean significant structural changes, however.

Options

Better definitions, more guidelines and additional funds will not solve the problem of applying the Pay Equity Act systematically and fairly to the employees in the health care sector. After careful consideration of the situation within the health care sector and of the recommendations made by various advocacy groups, we would recommend:

1. That a large, multi-service hospital be used as a model to determine wage adjustments for each major female job class in the health care sector. These dollar adjustments would then be required for each of these job classes in any Ontario establishment receiving the majority of their funding from the government. This scheme would have the following advantages from the point of view of advocacy groups:
    a) wage adjustments would be systematically distributed, ensuring that women would equally benefit from attempts to compensate for systemic discrimination
    b) regional differences which are argued to reflect market pressures would be maintained

c) differences among union contracts would be maintained, as would those between non-union and union employees

d) centrally bargained wage rates would be retained

e) large sums would be saved on the development of Pay Equity Plans.

2. Proportionate comparisons. Combined with the above recommendation, proportionate evaluation would ensure that all female job classes had a comparator. It would overcome the problem of leaving RNs and therapists with only a male janitor as a comparator. A solution on its own, however, proportionate evaluation would still leave many women in smaller establishments without a comparator of equivalent worth.

3. Wage adjustments should be widely publicized. Secrecy has long been a factor in maintaining wage discrimination and women can only properly evaluate their own Pay Equity Plan if they can compare it to others.

Appendix I

Associations Contacted

1. Association of Large Ontario Health Agencies
2. Association of Nurse Executives
3. Association of Nurse Executives of Metro Toronto
4. Association of Municipalities
5. Association of Ontario Health Centres
6. Association of Ontario Home Care Associates
7. Canadian Association of Optometrists
8. Canadian Memorial Chiropractic College
9. Canadian Society of Laboratory Technologists
10. Ontario Association of Children's Mental Health Centres
11. Ontario Association of Health Care Centres
12. Ontario Association of Medical Clinics
13. Ontario Association of Medical Radiation Technologists
14. Ontario Association of Speech/Language Pathologists and Audiologists
15. Ontario Chiropractic Association
16. Ontario College of Certified Social Workers
17. Ontario College of Pharmacists
18. Ontario Dental Association
19. Ontario Dental Hygenists Association
20. Ontario Dental Nurses and Assistants Association
21. Ontario Dental Nurses' Association
22. Ontario Hospital Association
23. Ontario Medical Secretaries' Association
24. Ontario Nursing Homes Association
25. Ontario Occupational Health Care Nurses Association
26. Ontario Society of Medical Technologists
27. Ontario Society of Nutritionists in Public Health
28. Ontario Society of Occupational Therapists
29. Red Cross - national, district and regional offices
30. Victorian Order of Nurses

Appendix II

Government Contacts

1. Ministry of Health -
    1. Interministerial contact for Pay Equity
    2. Consultant, Employment Equity
    3. Community Health Programs Branch; Home Care Program; Health Service Organisation; Community Health Program
    4. Placement Coordination Services
    5. Public Health Branch
    6. Information and Resources Service Branch
    7. District Health Council Program
    8. Ambulance Services Branch
    9. Mental Health Operations Branch
    10. Community Mental Health Branch
    11. Addiction Research Foundation
    12. Ontario Cancer Treatment and Research Foundation
    13. Nursing Homes Branch
    14. Laboratory Services Branch

2. Ministry of Labour, Library Services

3. Management Board of Cabinet, Human Resources Secretariat

4. Ontario Women's Directorate

5. Ministry of Skills Development

6. Statistics Canada - Toronto Services
   Economic Division

7. Health and Welfare Canada, Information Services

Appendix III

Interviews with Unions

1. Ontario Public Service Employees Union - OPSEU
2. Canadian Union of Public Employees - CUPE
3. Ontario Federation of Labour - OFL
4. Service Employees International Union - SEIU
5. Ontario Nurses' Association
6. The Association of Allied Health Professionals : Ontario

Appendix IV

1. Minority Group Contracts
2. Disabled Women's Network
3. Cross Cultural Communication Centre
4. Ontario Human Rights Commission, Race Relations Division
5. Women Working With Immigrant Women
6. Immigrant Women's Health Centre
7. Coalition of Visible Minoruty Women
8. Ontario Task Force on Access

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Table 1

Major Establishments in the Ontario Health Sector

Establishment	Number
Hospitals	250
Public	222
Private	18
Psychiatric	10
Nursing Homes	333
Adult Community Mental Health Centres	236
Home for Special Care	226
Laboratories	491
Public	12
Private	224
Specimen Collection Centres	255
Ambulances	175
Public	9
Private	166
Community Health Service Organisations	34
Victorian Order of Nurses	33
Ontario Cancer Treatment Research Foundation	30
District Health Councils	26
Detoxification Centres	25
Placement Coordination Services	19
Community Health Centres	17
Children's Treatment Centres	16
Red Cross	7+
Laundries, etc.	3+
Foundations, etc.	5+

Physicians and Dentists Offices	11,000+*
Registries	20+

Sources: Ontario Ministry of Health, Hospital Statistics, 1986/87. Variouss Ontario Government Departments and Agencies

Note: These numbers are based on seperate pieces of information collected from a variety of individuals from within the Ministry of Health. They are offered as an indication of the total number; not as a precise count of all establishments. The plus sign indicates that there may be more establishments than given here but we were unable to obtain a precise count.

* Based on the assumption that at least half of the doctors and dentists work in private practice.

Table 2

Medical Personnel: Predominately Female Occupations

Ontario 1986

Occupation	% Female
Nurse Therapy and Related Occupations	
Imp. Nurse Therapy and Related Ass.	90.5
Supervisors: Nurse Therapy and Related	93.9
Nurses: Grads and Training	96.5
Reigstered Nurses' Assistants	94.0
Nursing Attendants	91.0
Audio and Speech Therapists	87.5
Pysiotherapists	87.7
Occupational Therapists	88.5
Nurse Therapy and Related Ass. Occup. NEC	88.6
Total: Nurse Therapy and Related	92.5
Other Occupations in Medicine and Health	
Imp. Other Occupations in Medicine and Health	74.4
Dieticians and Nutritionists	94.4
Radiological Technicians and Technologists	84.9
Med. Lab. Technicians and Technologists	76.0
Dental Hygenists and Assistants	98.5
Respiratory Technicians	62.5
Other Occup. in Medicine and Health	83.4
Total: Other Occup. in Medicine and Health	75.1
Diagnosis and Treatment Occupations	
Health Diagnosis and Treatment NEC	63.1
Total: Diagnosis and Treatment	23.5
Total: Occupations in Medicine and Health	79.8
Other Related Occupations	
Administrators in Medicine and Health	65.4
Psychologists	64.0
Social Workers	70.0

Source: Calculated from unpublished 1986 Census Data.

Table 3

Medical Personnel: Predominately Male Occupations and "Neutral" Occupations

Ontario: 1986

Occupation	% Male
Diagnosis and Treatment Occupations	
Imp. Health Diagnosis and Treatment	72.6
Physicians and Surgeons	77.9
Dentists	86.6
Osteopaths and Chiropactors	82.1
Total: Health Diagnosis and Treatment	76.5
Other Occupations in Medicine and Health	
Optometrists	74.1
Denturists	81.9
Total: Other Occup. in Medicine and Health	24.9
Nurse Therapy and Related Occupations	
Orderlies	85.7
Total: Nurse Therapy and Related Occup.	7.5
Neutral Occupations	
Dispensing Opticians	57.7
Pharmacists	50.5

Source: Calculated from unpublished 1986 Census Data

Table 4

Examples of Hourly Wages In Female-Dominated Jobs, 1986

Job	Minimum	Maximum
Clerical		
Cashier 1	9,66	10,09
Clerk, supply	9,35	9,72
Office Administration	9,80	10,26
Typist	10,00	10,45
Medical Records	10,80	11,29
Service		
Housekeeping		
non-union	7,75	9,84
union	9,58	10,01
Dietary Aide		
non-union	7,75	9,84
union	9,58	10,01
Nurse Therapy		
Health Care Aides		
non-union	7,85	9,84
union	10,52	10,68
RNA		
non-union	9,57	12,13
union	11,29	11,41
RN		
non-union	13,61	17,31
union	15,85	18,55
private clinic	12,00	16,00
Other Medical		
Dental Assistant	8,80	10,51
Lab Assistant		
non-union (private)	8,52	11,52

union	12,21	11,52
Technician		
non-union	12,65	14,25
union	13,09	15,73
Technologist 1	15,08	16,90
Physiotherapist	16,30	16,90
Social Worker	15,81	19,24

Sources: These wages were gathered from a wide variety of sources to create a composite outline. Data came from unions, employers, Associations and individuals. The Management Bureau of Canada, Human Resource Secretariat provided some wage data and some were obtained from Labour Canada, *1985 Wage Rates, Salaries and Hours of Labour*. Data on dental hygenists come from Pat M. Johnson who generously shared material she has collected for her doctoral dissertation at the University of Toronto.

Table 5

Examples of Hourly Wages in Male Dominated Jobs, 1988

Job	Minimum	Maximum
Biomedical Engineer	17,09	20,97
Engineer, NEC	21,33	22,31
Paramedic union	16,65	18,37
Plasterer	14,03	14,43
Maintenance 1 union	11,41	11,92
Porter	10.91	11,40

Source: Same as Table 4

TABLE 6

Registered Nurses, Employed in Nursing and Working in Ontario, classified by Type of Employing Institution and Type of Position, 1987

Type of Position	Type of Employing Institution Hospital	Nursing Home/ Home for Aged	Educ. Instit.	Public Health	Home Care/ Visiting Nurse	Comm. Health Centre	Occup. Health	Phys./ Dentist Office	Other	Not Stated	Total
Director	474	527	55	58	110	11	37	9	154	7	1,442
Associate Assistant Director	221	95	14	24	31	-	6	1	30	4	426
Instructor	519	17	1,515	62	12	5	11	10	50	12	2,213
Supervisor/Coordinator	2,305	732	108	255	648	59	195	77	286	13	4,678
Head Nurse	2,664	1,010	28	13	33	22	157	154	115	4	4,200
General Duty/Staff	45,656	2,771	212	2,170	2,554	264	619	1,471	1,264	95	57,076
Clinical Specialist	374	8	18	38	11	8	41	53	44	1	596
Other/Not Specified	2,767	314	235	215	392	94	602	1,269	1,684	532	8,104
Total	54,980	5,474	2,185	2,835	3,791	463	1,668	3,044	3,627	668	78,735

EG/f-150

Source: College of Nurses of Ontario.

TABLE 7

Registered Nurses, Employed in Nursing and Working in Ontario, classified by Type of Position and Highest Qualification in Nursing, 1987

Type of Position

Highest Qualification in Nursing	Director	Associate Director	Supervisor/ Co-ordinator	Clinical Specialis	Instructor	Head Nurse	General Duty	Other	Not Specified	Total
Basic Diploma	398	109	1,701	180	280	1,904	34,802	2,987	1,294	43,655
Diploma & Other	327	75	1,237	145	233	1,276	11,458	1,333	319	16,403
Diploma & Certificate	180	64	616	36	190	451	3,454	500	135	5,626
Baccalaureate (Nursing)	243	93	779	100	970	416	5,699	727	183	9,210
Baccalaureate (Other)	92	22	201	15	167	120	1,410	267	97	2,391
Masters (Nursing)	78	34	52	83	154	12	67	73	16	569
Masters (Other)	107	25	88	34	192	18	105	142	31	742
PhD (Other)	12	2	3	1	23	1	13	15	1	71?
PhD (In Nursing)	5	2	1	2	4	2	47	2	3	68?
Total	1,442	426	4,678	596	2,213	4,200	57,005	6,046	2,079	78,735

Source: College of Nurses of Ontario

TABLE 8

stered Nursing Assistants, Employed in Nursing and Working in Ontario, classified by type of Employing Institution, 1983-1987

Type of Employing Institution	1983		1984		1985		1986		1987	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
spital	17,157	74.29	17,066	72.12	17,614	70.6	18,362	71.4	18,053	70.3
rsing Home/Home for the Aged	3,374	14.61	3,551	15.01	3,780	15.2	3,987	15.5	4,015	15.6
ency/Self-Employed	346	1.50	93	.39	134	.5	956	3.7	225	.9
blic Health Agency	184	.80	206	.87	218	.9	217	.8	220	.9
me Care/Visiting Nurse	224	.97	367	1.55	393	1.6	458	1.8	419	1.6
mmunity Health Centre	78	.34	100	.42	107	.4	126	.2	133	.5
cupational Health	145	.63	142	.60	169	.7	200	.8	205	.8
ysician/Dentist Office	532	2.30	535	2.26	634	2.5	680	2.6	698	2.7
her	488	2.11	652	2.76	960	3.8	254	1.0	1,180	4.6
t Stated	567	2.46	952	4.02	938	3.8	477	2.0	520	2.0
AL	23,095	100.00	23,664	100.00	24,947	100.00	25,717	99.8	25,668	100.00
nge over Previous Year	+1,182	+5.4	+569	+2.5	+1,283	+5.4	770	+3.1	-49	-.2

Source: College of Nurses of Ontario

TABLE 9

1987 Salaries of RNAs and HCAs in Nursing Homes and Homes for the Aged*

UNIONS	Length of Employ-ment	NursingHomes			Homes for the Aged		
		RNA	HCA	% More for RNA	RNA	HCA	% More for RNA
SEIU(1) - Extendicare group nursing homes - one Toronto and two Simcoe-area homes for the aged	start	$10.41	$9.74	7%	$9.04-$10.07	$8.83-$9.98	1-2%
	1 year	$10.72	$10.04	7%	$9.30-$10.23	$9.13-$10.10	1-2%
	2 year	$11.03	$10.36	6%	$9.56-$10.45	$9.43-$10.22	1-2%
	3 year	n/a	n/a	n/a	$10.62	n/a	n/a
Christian Labour Association(2) - Bestview and Versa Care nursing home chains - only one Home for the Aged in Owen Sound (rates currently being negotiated)	start	$10.74	$9.65	11%	n/a	n/a	n/a
	1 year	$11.07	$9.99	11%	n/a	n/a	n/a
	2 year	$11.33	$10.24	11%	n/a	n/a	n/a
	3 year	$11.48	$10.37	11%	n/a	n/a	n/a
CUPE(3) - same rates for both nursing homes and homes for the aged - Toronto-area homes for the aged	start	$10.02-$11.09	$8.83-$10.45	6-14%	$10.02-$11.09	$8.83-$10.45	6-14%
	1 year	$10.53-$11.49	$9.43-$11.01	4-12%	$10.53-$11.49	$9.43-$11.01	4-12%
	2 year	$10.76-$11.39	$9.73-$10.71	6-11%	$10.76-$11.39	$9.73-$10.71	6-11%
	3 year	$10.96-$11.55	$10.02-$10.85	7-9%	$10.96-$11.55	$10.02-$10.85	7-9%

Sources: (1) Service Employees International Union, rates effective to December 31, 1987.
(2) Christian Labour Association, rates effective to December 1, 1987.
(3) Canadian Union of Public Employees, rates effectie as of July 1987.

* Table prepared by Ontario Association of Registered Nursing Assistants, January 1988.

TABLE 10

1985 ONTARIO PUBLIC HOSPITAL WORKFORCE SURVEY*

Number of Employees by Sex and Occupational Group**

Occupational Group	Number of Males	Number of Females	Total Employees	Females as a Percent of Total
01/02 Chief Executive/ Senior Management	765	470	1,235	38.06
03 Middle Management	1,600	3,333	4,933	67.57
04 Supervisory/ Nurses/Technical	1,272	5,339	6,611	80.76
05 Nurses	616	39,963	40,579	98.48
06 Technical/Professional	2,762	11,415	14,177	80.52
07 Nursing/Technical Support	4,034	18,998	23,032	82.49
08 Maintenance/Trades	2,779	60	2,839	2.11
09 Clerical/ Secretarial	465	17,657	18,122	97.43
10 Housekeeping/ Dietary/Other Services	7,337	17,428	24,765	70.37
Total	21,630	114,663	136,293	84.13

* The following tabulations are based on data from all of the 221 public hospitals in the province.

** Full-time and regularly scheduled part-time employees are included.

Source: Ministry of Health, March, 1987

TABLE 11

SALARY SCHEDULE

Effective September 29, 1986 - September 28, 1987

	Start	After 1 Year	After 2 Years
R.N.A.	11.03	11.23	11.44
Cook	9.72	9.94	10.15
Aides - Dietary, Housekeeping & Laundry	9.41	9.62	9.83
Lead Hand - Housekeeping & Laundry	9.72	9.94	10.15
Clerk	9.72	9.94	10.15
Ambulance Attendant	9.72	9.94	10.15
Maintenance Man	10.13	10.35	10.55

Source: Collective Agreement

Appendix I

Associations Contacted

1. Association of Large Ontario Health Agencies
2. Association of Nurse Executives
3. Association of Nurse Executives of Metro Toronto
4. Association of Municipalities
5. Association of Ontario Health Centres
6. Association of Ontario Home Care Associates
7. Canadian Association of Optometrists
8. Canadian Memorial Chiropractic College
9. Canadian Society of Laboratory Technologists
10. Ontario Association of Children's Mental Health Centres
11. Ontario Association of Health Care Centres
12. Ontario Association of Medical Clinics
13. Ontario Association of Medical Radiation Technologists
14. Ontario Association of Speech/Language Pathologists and Audiologists
15. Ontario Chiropractic Association
16. Ontario College of Certified Social Workers
17. Ontario College of Pharmacists
18. Ontario Dental Association
19. Ontario Dental Hygenists Association
20. Ontario Dental Nurses and Assistants Association
21. Ontario Dental Nurses' Association
22. Ontario Hospital Association
23. Ontario Medical Secretaries' Association
24. Ontario Nursing Homes Association
25. Ontario Occupational Health Care Nurses Association
26. Ontario Society of Medical Technologists
27. Ontario Society of Nutritionists in Public Health
28. Ontario Society of Occupational Therapists
29. Red Cross - national, district and regional offices
30. Victorian Order of Nurses

Appendix II

Government Contacts

1. Ministry of Health -
    1. Interministerial contact for Pay Equity
    2. Consultant, Employment Equity
    3. Community Health Programs Branch; Home Care Program; Health Service Organisation; Community Health Program
    4. Placement Coordination Services
    5. Public Health Branch
    6. Information and Resources Service Branch
    7. District Health Council Program
    8. Ambulance Services Branch
    9. Mental Health Operations Branch
    10. Community Mental Health Branch
    11. Addiction Research Foundation
    12. Ontario Cancer Treatment and Research Foundation
    13. Nursing Homes Branch
    14. Laboratory Services Branch

2. Ministry of Labour, Library Services

3. Management Board of Cabinet, Human Resources Secretariat

4. Ontario Women's Directorate

5. Ministry of Skills Development

6. Statistics Canada - Toronto Services
   Economic Division, Ottawa

7. Health and Welfare Canada, Information Services

Appendix III

Interviews with Unions

1. Ontario Public Service Employees Union - OPSEU
2. Canadian Union of Public Employees - CUPE
3. Ontario Federation of Labour - OFL
4. Service Employees International Union - SEIU
5. Ontario Nurses' Association
6. The Association of Allied Health Professionals : Ontario

Appendix IV

1. Minority Group Contracts
2. Disabled Women's Network
3. Cross Cultural Communication Centre
4. Ontario Human Rights Commission, Race Relations Division
5. Women Working With Immigrant Women
6. Immigrant Women's Health Centre
7. Coalition of Visible Minority Women
8. Ontario Task Force on Access

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